

THE UNIVERSITY OF HULL

The Experience of Different Types of Mania
in Bipolar Disorder

being a Thesis submitted for the Degree of
Doctorate in Clinical Psychology
At the University of Hull

By

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July 2010

Acknowledgements

First and foremost I would like to thank all the participants who kindly accepted to take part in my research. Each of them contributed from the heart and I felt privileged to have had the opportunity to meet them and hear their open and honest experiences of living with bipolar disorder. The honesty, hope and strength shown by these participants was truly inspirational and heart warming.

Secondly, I am grateful to the MGGS (2007) board within the Ministry of Education, Youth and Employment in Malta for granting me the scholarship which part-funded this course of study. I would also like to thank Professor Dominic Lam for his mentorship during this period of study and for bringing me back to reality when I wandered off with my ideas. His contribution was invaluable and I am grateful for his commitment to the field of bipolar disorder, expertise and advice. I would like to thank Dr Chris Clark for helping me in conducting the analysis of the Empirical Paper which helped me further my understanding in qualitative research methods.

I would also like to thank my friends Jennifer and Georgia (Trainee Psychologists). They proved to be real friends in need and their inspirational influence will remain with me always.

Finally, I would like to thank my sisters Alison, Stephanie and my brother Joseph, who from far away have supported me throughout the three years and the course of this research. Special thanks go to my parents, Alfred and Anna for helping me embark on this training course. Without their financial assistance and relentless support I would not have been able to pursue this line of work. Finally, I would like to thank my fiancé Gianluca for his support and patience and my baby son Antonio Francesco for his unconditional love.

Overview

This portfolio thesis consists of two journal articles relating to bipolar disorder. The first article documents a systematic literature review on different types of family interventions for bipolar disorder. The second article is a report of an empirical and exploratory study of peoples' experience of living with different types of mania.

The systematic literature review identifies and critically evaluates an existing body of research of the effectiveness of using family interventions for bipolar disorder. The study provides information about the quality of the existing literature and outlines the different methods of family therapy as applied in clinical practice. Finally, it critically evaluates the interventions' influence on family processes and summarises these findings. The article concludes with a discussion on the clinical implications of the systematic review and identifies certain issues which remain unexplained, thus needing further follow-up through research and clinical practice.

The empirical paper documents a study which used qualitative methodologies to explore the experiences of different types of mania. The introduction summarises main findings from factor analytic studies that identified different and common factors in the make-up of mania in bipolar disorder. Specifically, the study examines the existence of different types or categories of mania.

The study involved semi- structured interviews which were analysed using Interpretative Phenomenological Analysis. The emerging themes are discussed and linked with the existing body of literature. The study identifies clinical and theoretical implications for the understanding of the development of mania. Areas requiring further research are identified and methodological implications are also discussed.

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Systematic Literature Review

What impact do family interventions for Bipolar Disorder have on families and familial processes?

Abstract

Background

Previous research investigating interventions which included family members and caregivers in the treatment of bipolar patients were shown to impact positively on patients' outcomes.

Although there is evidence that some family interventions showed improved relapse rates, other studies did not show any advantages in using family intervention over other modes of intervention and the evidence remains mixed.

Purpose

To review the existing literature so as to identify processes that have changed consequent to a family therapy treatment.

Results

In the process of conducting this review, twelve studies examining the usefulness of family therapy for bipolar disorder have been identified as meriting inclusion in this review. Family interventions included psychosocial intervention for family members and patients, with patient present or not present. Furthermore, studies evaluating family interventions were not restricted to individually based family interventions but included interventions with groups of families.

Conclusions

Overall patients with bipolar disorder seemed to thrive with more knowledgeable and supportive families. The different approaches in family therapy had a positive impact on families and proved successful in changing some family processes /dynamics which contributed to better outcomes for patients and their families. The impact of these treatments requires further study to help elucidate underlying mechanisms.

Introduction

Bipolar disorder is characterised by severe labile moods. According to the DSM-IV, people suffering from bipolar disorder I experience mania and depressive episodes whereas bipolar disorder II is characterised by episodes of hypomania and depression. Mania however remains the defining feature of bipolar disorder, APA (1994). More recently, Aksiskal, Merikangas, Angst et al (2007) proposed that a wider spectrum of bipolarity has to be acknowledged so that the illness is identified more often. It is an important source of impairment in people affected by the illness (Justo, Soares & Calil, 2009). Bipolar disorder affects both genders and it is estimated that 50% of people affected by it will attempt suicide (Jamison, 2000). Pharmacological treatment is a fundamental therapy to managing mania, nonetheless despite continual treatment, patients with bipolar disorder still experience relapses (Gitlin, Swendsen, Heller & Hammen, 1995).

Although bipolar disorder is marked by genetic factors, there is a general consensus that psychosocial factors are heavily involved in its development (Aksiskal et al 2007). There seems to be a correlation with extreme stress caused by major life events, (Johnson, Cueller, Ruggero et al, 2008). There is also evidence that life events inside the family context are connected to symptoms of bipolarity and expressed emotion is an important factor in symptoms' presentation (Miklowitz, Coville & Low 2008).

There is a general consensus that bipolar disorder affects relationships in the family and these in turn affect the course of the illness, (Miklowitz, Rosenfarb, Goldstein et al 2001). The morbidity caused by the disorder has been shown to cause burden in the lives of family members and other caregivers of patients with bipolar disorder (Reinares, Vieta, Colom, et al, 2006). Consequently

burden was found to be related to patients' symptoms and behaviours and escalating depressive symptoms but did not have any impact on manic symptoms (Reinares et al 2006).

Evidence collated by Miklowitz et al (2001) and Miklowitz, Goodwin, Bauer & Geddes (2008) suggest that interventions which include family members and caregivers in the treatment of bipolar patients impact positively on patients' outcomes. However, the review conducted by Justo et al (2009) was not so favourable as the authors concluded that although there is evidence that some family interventions showed improved relapse rates, other studies did not show any advantages in using family intervention over other modes of intervention, mainly standard pharmacotherapy thus the evidence with regards to its efficacy remains mixed. This is where family interventions seem to fall short as their superiority over other modes of treatments in maintaining wellness cannot be fully established. Moreover, in Justo et al (2009) review, the impact of family interventions on family factors and processes that might have impacted positively on patients and relatives, regardless of relapse, have not been considered.

Therefore, the aim of this review was to obtain and evaluate all relevant trials that conducted research evaluating the effectiveness of diverse forms of family interventions for bipolar disorder and present the details of these other factors or family processes which have been previously omitted. The question that this review is trying to answer is: What impact do family interventions have on families and familial processes ?

For the purpose of this review, family interventions include any type of psychosocial intervention for family members and patients with bipolar disorder, with or without the participation of the identified patients. Studies evaluating family interventions were not restricted to individually based family interventions but included interventions with groups of

families. Family processes include psychosocial functions and relationships within a family unit.

Method

Search Strategy

Initial preliminary searches were conducted to identify the most appropriate search terms for this review by combining different terms for “bipolar disorder” and “family therapy”. The searches were then scrutinised for potential key studies. The first part of the search included a number of variants for bipolar disorder, as older studies (prior DSM-III) would have used a different term to bipolar disorder, for e.g. manic depression. The second part of the search included “family therapy” and various forms of family therapy preceding this phrase, along with “family intervention” and “family treatment”. The various search terms for different forms of family therapy were subsequently abandoned as they were not necessary, as key studies were found by the phrase “family therapy” alone.

Subsequently, “bipolar disorder, OR “affective disorders”, OR “mood disorder” in combination with “family therapy” OR “famil* w3 therap*” OR “family intervention” OR “family treatment” yielded the best number of key studies , hence considered the most valid and adopted (see Appendix A). The search terms were then applied to four electronic databases, namely, Cinahl, Medline, Psycharticles and Psychinfo, all of which are available on the EMBASE interface.

This ensured that a range of psychological, medical and allied health information and publications were accessed. The Cochrane Database was also consulted, and a hand search of key journals was conducted (see Appendix B) as this was considered necessary to perform a comprehensive search. Later, a search through the reference lists from all included studies was

conducted. This exercise further helped the author to establish the validity and importance of the key papers included in this study. In fact, the key papers were noted to have received multiple attention from different authors.

Inclusion Criteria

Studies were considered to be eligible for inclusion if they met the following criteria: evaluated a family intervention or therapy for bipolar disorder in adults over the age of eighteen, showed clear qualitative and quantitative patient outcomes as few studies included family outcomes, however, all the studies included information about family processes and included a follow-up period of not less than 12 weeks. Furthermore, the interventions could be delivered to individuals with bipolar disorder and at least one family member (in close contact), dyads or couples or multi-family group interventions for family members and bipolar patients or family members or carers on their own. For the purpose of this review all forms of family therapy interventions were considered. Literature reviews were excluded from the study.

Exclusion Criteria

The reasons for exclusion involved the inclusion of children and adolescents and participants who had experienced schizophrenia and schizoaffective disorder or other major psychiatric illness. Other studies were excluded because family therapy was conducted on a heterogeneous sample of psychiatric disorder patients along with bipolar patients. Another number of papers were excluded because the main focus were psychopharmacology outcomes.

A much smaller sample of studies were excluded because the intervention focused on elderly psychiatric patients or reported co-morbidity with addictions. An even smaller number of studies' general focus was on Expressed Emotion rather than bipolar disorder, hence excluded on this basis. Book chapters, systematic literature reviews, commentaries and duplicates were also excluded.

Data Extraction

A purposefully designed proforma was used for data extraction. Information describing the design, methodology, participant/patients sample, type of family intervention and outcomes was collected.

Quality Control

The studies were checked for quality, by using the checklists recommended by the National Institute for Health and Clinical Excellence (NICE 2007). The checklist provided an easy to use algorithmic formula to assign to each study, depending on the rigour and standards put into practice when conducting the research. In fact, based on factors such as clearly specified objective of the study, selection and randomisation of sample, quality of intervention, outcomes and details of confounding variables management, each study was assigned one of the following quality rating, namely '+', '++' or '-'.

Results

Search Results

The electronic search yielded a total of 275 papers, 250 of which were excluded based on reading the title and following from this and when deemed necessary, the abstract or full paper.

Of the remaining 24 papers, one study was excluded because it did not report any formal outcome measures other than the group evaluations derived from subjective reports of participants (Bremman, 1995). This study was not included as the proforma used for the purpose of this review was only adequate for studies that included quantitative measures. Also a homogenous sample was deemed necessary to allow for a better comparison between studies. Another 3 studies were excluded from this review as they either reported findings from other major studies (reviewed here) or were a continuation project from an earlier study (see *Table 3*,

Appendix C) and an additional 5 studies were excluded as well, as although a family intervention was used, the outcomes used to assess the treatments' effectiveness, did not directly relate to bipolar disorder (see *Table 4*, Appendix C).

The hand search of key journals identified 7 relevant studies, 1 of which was excluded because it was a report on a survey conducted on other psychosocial studies, including family therapy. The remaining 6 papers were identical to the ones identified by the electronic search and were included in this review, as they met all the inclusion criteria and the quality checklist (NICE, 2007) adopted for the purpose of this review (see *Table 1*). Finally, the Cochrane Database search yielded 1 study. This was a systematic literature review and hence was excluded from this review, on this basis.

***Table 1:** A brief outline of Studies obtained from Electronic Search which were not eligible for inclusion*

Outline of Excluded Studies	Code/ No
1. Children & Adolescents and their families were the participants of the study	C&A 62
2. Psychiatric and mental health disorders not specific only to bipolar disorder	P/B 29
3. Other psychosocial/psychotherapy treatments not specific to FT	TnotFT 35
4. Focus on Schizophrenia & Schizoaffective Disorders	S/SA 21
5. Systematic literature reviews	SLR 19
6. Emphasis on Psychopharmacology	MED

	31
7. Book chapters	B/C 13
8. Duplicates	Dup 14
9. Commentaries	Com 8
10. Co-morbidity with Axis II disorders and addictions	Co-mor 4
11. Expressed Emotion	EE 7

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes/ Elucidation of Treatment	Reported Findings
Clarkin, Glick, Gretchen, Spencer, Lewis, Peyser, DeMane, Good-Ellis, Harris & Lestelle, V. (1990) (+)	<p>Allocation: Randomised assignment.</p> <p>Blinding: None</p> <p>Duration: 6 sessions (45 min- 1 hour each).</p> <p>Follow-up: 6 and 18 months after treatment.</p> <p>Setting: An In-patient Unit: The average range of stay (<i>SD</i>) 36 days.</p>	<p>Diagnosis: Affective Disorders (N=50) Unipolar (N= 29)/Bipolar/ (N=21: n=13, manic; n=7 depressed; n=1 mixed episode) DSM-III criteria</p> <p>Sex: Female N=13 (45%) Male N=17 (55%)</p> <p>Age: 35.9 (<i>SD</i> 14.5)</p> <p>Inclusion Criteria: Availability of the family and a length of stay sufficient enough to warrant participation in the study.</p>	<p>Two treatment Groups:</p> <p>Within the first 2 days of hospitalisation, patients were admitted to:</p> <p>Family Intervention (IFI) plus standard multimodal hospital treatment (which included diagnostic and drug services with individual and group therapies).</p> <p>Standard multimodal hospital treatment.</p>	<p>Patients and family were assessed at different points in time with the:</p> <p>Global Assessment Scale of symptomology and role functioning (GAS).</p> <p>Psychiatric Evaluation Form (PEF).</p> <p>Role Performance Treatment (RPTS).</p> <p>Ratings of IFI goals.</p>	<p>Family sessions were conducted by one of two experienced family therapists.</p> <p>Treatment manual used.</p> <p>The goals of the Family Intervention were: Acceptance and understanding of the illness. Identification of stressors. Identification of stress within and without the family context. Focus on unhelpful family interactions. Planning strategies to manage/ minimise stress.</p>	<p>At 18 months, bipolar patients showed better outcomes with (IFI) ($P<0.05$). This effect however was limited to female patients.</p> <p>Unipolar patients did better without it. The overall positive effect was attenuated over time for female patients. A negative effect was registered for male patients.</p>

Table 2: Summary of Included Studies

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Honig , Hofman, , Rozendaal, & Dingemans, 1997- (An extension study of Honig 1995) (++)	Allocation: Randomised assignment. Blinding: Yes, partial. Duration: 4 months. Follow-up: 2 years. Setting: Outpatient psychiatric unit	Diagnosis: Bipolar Disorder DSM-IV. (N=52). Sex: Female (N=N/A) Male (N= N/A). Age: 43.8 years (<i>SD 13</i>) Inclusion Criteria: Availability of key relatives	Two groups: Treatment group received a family based psycho-education sessions of participants with key relatives (n=29): n=19 with partners, n=6 with parent and n=4 significant other. No Treatment-Waiting list condition (n=23)	EE in this study was considered an important variable. EE levels of significant others was measured with the Five-Minute Speech Sample (FMSS) pre and post treatment for Treatment and Control Group. Brief Psychiatric Rating Scale. Additional Participants' and Relatives' evaluations.	Author developed a psycho-educational programme for bipolar disorder. Focus on information, methods of coping, recognition for continued support for patients and family members.	Nine key relatives (31%) in the treatment group changed from high to low EE rating compared to none in the Control Group.(<i>P</i> =0.03).

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Reinares, Colom, Sanchez-Moreno, Martinez-Arán, Comes, Goikololea, Benabarre, Salamero, & Vieta, 2008. (++)	Allocation: Randomised assignment. Blinding: Yes. Duration: 12 weeks intervention Follow-up: 1 year. Setting: Barcelona Bipolar Disorders Centre.	Diagnosis: Bipolar Disorder DSM-IV, euthymic for at least 3 months (scoring ≤ 9 on the HDRS and ≤ 7 on the YMRS. (N= 113). Sex: Female (n=61), Male (n=52). Age: 34 years (<i>SD</i> 9.98) Inclusion Criteria: Pharmacological treatment. Living with a relative or partner for at least a year. Exclusion Criteria: DSM-IV Axis I co-morbidity, L.D. or non-psychiatric illness.	Two groups of caregivers. Allocated to the relatives' psycho-education group (n= 57). Allocated to the control group (n=56).	Complete symptom assessment at intake. DSM-IV (SCID) Axis 1&2. Hamilton Depression Rating Scale (HDRS). Young Mania Rating Scale (YMRS). Social and Occupational Functioning Assessment. Medication compliance assessment.	Psycho-education intervention for caregivers of bipolar disorder patients. The programme consisted of the following components: psycho-education about the illness; symptoms, prodromes and trigger identification; information on medication; communication enhancement training and problem solving skills; legal and social resources.	During the period of the study, 61 patients fulfilled criteria for a recurrence episode, 37 (66%) were from the control group and 24 (42%) were from the intervention group. (= 6.53, p=0.011). Survival analysis did not suggest differences in depressive or mixed episode relapses, however time for hypomanic/ manic relapses was longer. ($\chi^2 = 5.84$; p=0.015).

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
D' Souza, Piskulic, & Sundram, 2009 (+)	Allocation: Randomised assignment. Blinding: None. Duration: 12 weekly sessions of 90 minutes each. Follow-up: Yes. (Number of weeks not reported). Setting: Research Institute.	Diagnosis: Bipolar Disorder DSM-IV diagnosis, remitted patients recruited within 1 month of being discharged from hospital (scoring ≤ 8 on the MADRS and ≤ 10 on the YMRS. (N= 58) and their companions/ caregivers. Sex: Female (n=61), Male (n=52). Age: 34 years (SD 9.98) Exclusion Criteria: DSM-IV Axis I co-morbidity, or substance dependence.	Two groups Allocated to the SIMSEP-BD (n= 27). Allocated to the TAU (Treatment as usual) (n=31).	DSM-IV (SCID) Axis1. Montgomery-Asberg Depression Rating Scale (MADRS). Young Mania Rating Scale (YMRS).	After 12 weeks, SIMSEP patients reverted to TAU. The SIMSEP-BD programme consisted of the following components: Familiarisation with the illness; symptoms, pharmacotherapy, psychotherapy, trigger (signal) identification, emergency planning, coping strategies, and legal, financial and social resources. TAU consisted of a weekly clinical review with a trained mental health worker and a monthly medication review.	The rate of relapse was significantly different (Fisher's exact test $p= 0.013$) for the two treatment groups, with the SIMSEP participants being less likely to relapse compared to the TAU group (OR = 0.16; 95% CI 0.04-0.70) and longer time to relapse, on average 11 weeks (hazards ratio of 0.19; 95% CI 0.05-0.68). This difference was true only for manic symptoms not depression.

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
van Gent & Zwart (1991) (++)	Allocation: Randomised assignment. Blinding: Yes, Duration: 6 months. Follow-up: Interview immediately after termination of sessions and 6 months later. Setting: University outpatient clinic.	Diagnosis: A diagnosis of Bipolar Disorder according to DSM-III R criteria (N=26). Sex: Female (N=N/A) Male (N= N/A). Age: 44.4years (<i>SD</i> 11) versus 55 (<i>SD</i> 10). Inclusion Criteria: Availability of key relatives.	Two groups of partners; patients were not included in the study. Treatment group received a family based psycho-education sessions (n=14) No Treatment-Waiting list condition (n=12)	The following measures were used for relatives: A knowledge test. Trait Anxiety Inventory. Interactional Problem Solving Questionnaire. Mood scales and the Symptom Checklist (SCL-90) were used with patients. Medication compliance was monitored	The aim of the sessions was to increase the partners' knowledge of BD, medication, social strategies and minimising anxiety	Changes before and after were reported using the ANOVA repeated measures test. Knowledge of illness $F = 3.61$ ($df = 2$), $p < 0.05$ Social strategies $F = 3.38$ ($df = 2$), $p < 0.05$ Lithium $F = 17.9$ ($df = 2$), $p < 0.005$. Patients' SCL-90 $F = 0.43$ ($df = 2$), n/s SCL-90 Anxiety $F = 3.31$ ($df = 2$), $p < 0.05$ and Trait Anxiety $F = 4.46$ ($df = 2$), $p < 0.02$.

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Miller, Keitner, Ryan, Uebelacker, Johnson, & Solomon 2008	<p>Allocation: Randomised assignment.</p> <p>Blinding: None.</p> <p>Duration: 12-16 weeks</p> <p>Follow-up: 2 years after treatment.</p> <p>Setting: University affiliated hospital.</p> <p>Treatment: Home & Laboratory based.</p>	<p>Diagnosis: Bipolar Disorder active episode (N= 92): mania (n=69), depression (n=18) and mixed episode (n=5) DSM-III-R.</p> <p>Sex: Female (N=52) Male (N= 40).</p> <p>Age: 39 years (<i>SD 13</i>)</p> <p>Inclusion Criteria: Currently active mood disorder. Aged between 18-65 years. No evidence of neurological problems or deficits. No substance misuse. Living or in contact with a significant other. English speaking. Written consent.</p>	<p>Three treatment groups:</p> <p>6-10 sessions of Family Therapy (Problem Centred Systems Therapy)plus pharmacotherapy (n=33).</p> <p>6 sessions of Multifamily Group Therapy plus pharmacotherapy (n=30).</p> <p>Pharmacotherapy alone (n=29).</p>	<p>Participants were initially assessed at intake and then monthly thereafter for recovery.</p> <p>Modified Hamilton Rating Scale for Depression.</p> <p>Bech-Rafaelson Mania Scale.</p> <p>Survival analysis.</p> <p>Compliance with medication was monitored</p>	<p>Family focused treatment consisted of three components: Psycho-education about the disorder, communication enhancement training and problem solving skills.</p> <p>All treatments was carried out by qualified staff.</p> <p>Multifamily Group Therapy was a semi-structured intervention. A manual was purposefully devised.</p> <p>Weekly group and individual supervision.</p>	<p>The proportion of recovered patients by the month did not differ between the treatment groups (log-rank $\chi^2 = 1.21$, $P = 0.55$).</p> <p>Only 58% of participants met the recovery criteria during the course of study. The median time was 8 months.</p>

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Solomon, Keitner, Ryan & Miller 2008 (++)	Allocation: Randomised assignment. Blinding: Yes. Duration: 3-4 months. Follow-up: 24 months Setting: University affiliated psychiatric hospital. Inpatients/ Outpatients	Diagnosis: Bipolar I manic patients who had recovered from the intake mood episode (N= 53) DSM-III-R of an original sample of 92. Sex: Female (60%). Male (55%). Age: 41 years (<i>SD</i> 13) Inclusion Criteria: Currently active mood disorder. Aged between 18-65. Contact with at least one family member. English speaking. Exclusion criteria: Substance misuse.	Three treatment Groups: Multifamily group therapy plus standard pharmacotherapy (n= 21). Individual family therapy (problem centred systems therapy) plus standard pharmacotherapy (n= 16). 6-12 (50 min) sessions were provided weekly or bi-weekly by mutual agreement. Pharmacotherapy alone (n= 16).	Patients were assessed at intake and monthly thereafter for 28 months. Modified Hamilton Rating Scale for Depression (HAM-D). Bech- Rafaelson Mania Scale (BRMS). Global Assessment of Functioning (GAF). Survival Analysis	Individual Family sessions were conducted by an experienced therapist (≥ 15 years). Problem Centered Systems Therapy of the family was used. Regular/ weekly supervision. Multifamily group therapy emphasised psycho-education and managing the illness within a format of group support. The sessions were conducted by two psychotherapists with ≥ 15 years experience.	Neither individual family therapy nor multifamily group therapy was significantly superior to pharmaco-therapy in preventing relapse, but fewer hospitalisations and pharmaco- therapy treatments were associated with multifamily group therapy. Frequency of recurrence ($=0.21$, P 0.90). Time to recurrence ($=0.56$, P 0.75). Frequency of Hospitalisation ($= 6.53$, P 0.75).

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Miklowitz, Richards, Simoneau & Suddath 2003 (++)	Allocation: Randomised assignment. Blinding: Yes. Duration: 9 months. Follow-up: 3,6, 9 month intervals post treatment. Setting: Patients' homes. Post episode interval (not experiencing an active episode).	Diagnosis: Bipolar patients (N=101): (n=14, depressed; n= 54, manic; n=33, mixed episode) according to DSM-III-R criteria. Sex: Female (60%). Male (55%). Age: 35.6 (<i>SD</i> 10.2) Inclusion Criteria: A diagnosis of bipolar disorder. Aged between 18-65 years. Close contact with family. Exclusion criteria: Substance misuse/ neurological disorder. Lack of transport. Unwilling to take medication. Non-English speaking.	Two treatment Groups: Family focused psycho-educational programme (FFT) plus standard pharmacotherapy (n=31). Crisis Management Intervention (as needed) plus 2 sessions of family education plus standard pharmacotherapy (n=70). All patients received medication management sessions for a year.	Patients were assessed at entry, a month later and 3 to 6 month intervals for up to two years after treatment. SCID at intake interview. Schedule for Affective disorders and Schizophrenia-Change version (SADS-C).	Family sessions were conducted by trained therapists. Regular/ weekly supervision. Use of a standardised manual. Family focused treatment consisted of three components: Psycho-education about the disorder, communication enhancement training and problem solving skills. Crisis Management Intervention (CM) emulated standard community care.	Patients who followed FFT were less likely to relapse and longer intervals between relapses than patients undergoing CM. ($\chi^2_{2/3} = 13.03, P = 0.005$). FFT patients remained remitted for longer intervals Wilcoxon ($z_1 = 8.71, P = 0.003$, hazard ratio 0.38; 95% CI) showed reductions in mood disorder symptoms, i.e. enhanced mood stability (Wilcoxon $z_1 = 9.54, P = 0.02$; hazard ratio 0.37, 95% CI) and medication compliance

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Simoneau, Miklowitz, Richards, Saleem, & George 1999 (+)	Allocation: Randomised assignment. Blinding: None. Duration: 9 months. Follow-up: 2 years. Setting: Patients were recruited from 4 different sites. Treatment: Home & Laboratory based.	Diagnosis: Bipolar Disorder active episode (N= 79 from an initial 101). DSM-III-R. Sex: Female 54%. Male 46%. Age: 34.2 years (<i>SD</i> 9.3) Inclusion Criteria: Currently active mood disorder. Aged between 18-60. No evidence of neurological problems or LD. No substance misuse. In contact with a significant other. Willingness to take medication	21 sessions of home based Family focused psycho-educational therapy (manual format). Family sessions involved the patient and his/her close relatives. Crisis management with naturalistic follow-up consisted of 2 sessions family psycho-education. Supportive crisis intervention was given in the form of telephone conversations and face-to-face sessions.	Participants were interviewed at 3,6,9,12,18 and 24 months. EE in this study was considered an important variable. The Camberwell Family-EE Rating Scale was administered to significant others. Family Interactional Assessment. Schedule for Affective disorders and Schizophrenia-Change version (SADS-C). Compliance with medication was also assessed.	Family focused treatment consisted of three components: Psycho-education about the disorder, communication enhancement training and problem solving skills. FFT was carried out by a trained therapist and a trainee (2 co-therapists). Weekly group and individual supervision.	Positive nonverbal behaviours were seen among patients and greater symptom improvement in the first year. The direction of such improvement could not be determined. $F(2,41)=6.10, P < 0.02$ for patients and $F(2,41)=3.15, P < 0.10$ for relatives. There was no observed difference in total negative verbal and non-verbal behaviour $F(1,41)=0.05, P > 0.10$. When symptom status, KPI & SADS-C assessments were co-varied, the difference remained significant $(F(1,40)=4.34, P < 0.05)$

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Rea, Tompson, Miklowitz, Goldstein, Hwang & Mintz 2003 (++)	Allocation: Randomised assignment. Blinding: Yes. Duration: 9 months Follow-up: 3 month intervals for year of active treatment and 1 year period follow-up, post treatment. Setting: In-patient Units (3 hospitals).	Diagnosis: Bipolar manic patients (N=51) DSM-III-R Sex: Female (60%). Male (55%). Age: 24.6 (<i>SD</i> 5.80) Inclusion Criteria: A diagnosis of bipolar disorder, (manic). Between the age of 18-45 years. Ability give written consent. On medication. Availability of one close family member. Exclusion criteria: Substance misuse/ CNS disorder	Two treatment Groups: Approached by hospital staff while hospitalised. 21 sessions of Family focused psycho-educational programme (FFT) plus standard pharmacotherapy (n=28). 21 sessions Individual treatment plus standard pharmacotherapy (n=25). All patients received medication management sessions for a year.	Patients were assessed at 3 month intervals during treatment: Brief Psychiatric Rating Scale (BPRS) Schedule for Affective disorders and Schizophrenia-Change version (SADS-C). Follow- up interview after 2 years.	Family sessions were conducted by trained therapists. Regular/ weekly supervision. Use of a standardised manual. Family focused treatment consisted of three components: Psycho-education about the disorder, communication enhancement training and problem solving skills. Individual intervention consisted of educating the patient, monitoring patient's awareness, crisis intervention and stress monitoring.	Patients who followed FFT were less likely to be re-hospitalised and experienced fewer mood disorders post treatment follow-up. ($t(1) = 5.04, p < 0.05$). Re-hospitalisation and relapse did not differ for both groups during the treatment itself. ($t(1) = 1.38, p < 0.10$).

Study ID/ Quality Rating	Methods	Participants	Interventions	Outcomes	Further Notes	Reported Findings
Ozerdem, Oguz, Miklowitz & Cimilli 2009 (+)	Allocation: Non- randomised. Volunteer participants. Blinding: None Duration: 9 months. Follow-up: 54.44 weeks (<i>SD</i> 24.96) Setting: Outpatient psychiatric unit.	Diagnosis: Bipolar Disorder DSM-IV, active manic or depressed. (N=10). Sex: Female (N=5) Male (N= 5). Age: 25.5 years (<i>SD</i> 8.07) Inclusion Criteria: Native Turkish speakers. Availability of key relatives.	One group. Treatment group received 21 sessions of family based psycho-education sessions of participants with key relatives (N=10). Pharmacotherapy (N=10)	Complete symptom assessment at intake. Global assessment of functioning scale (GAF). Clinical Global Impression (CGI). Observations of the family through the LOCF (last observation carried forward) technique.	Family Focused Intervention developed for the Turkish population. (Ecological Validity established) Family focused treatment consisted of three components: Psycho-education about the disorder, communication enhancement training and problem solving skills.	Patients showed increased GAF scores, reductions in CGI scores and reductions in the average number of episodes.

Results

Participants

The total number of participants with bipolar disorder was 637. All participants were adults with a mean age of 35.48 years with a mean standard deviation of 11.37. Further information on characteristics of the participants is presented in the Summary of included studies (*see Table 2*). The interventions reviewed included family interventions used for bipolar disorder patients in two distinct phases of the illness, the acute phase or the remitted phase; both outpatients and inpatients were included.

The meaning of “family” was an extended one, as it included a spouse or partner (D’Souza, Piskulic & Sundram 2009; Honig, Hofman, Rozendaal & Dingemans 1997; Miklowitz, George, Richards et al (2003), Rosenfarb, Goldstein, Harmon et al (2003); Clarkin, Glick, Gretchen, et al (1990); Miller, Keitner, Ryan et al, (2004); Retzer, Simon, Weber et al (1991) and Simoneau, Miklowitz, Richards et al (1999) and living in the same home. Biological relatives such as parents and siblings were more common in the studies conducted by Ozerdem, Oguz, Miklowitz & Cimilli (2009) and Reinares, Vieta, Colom et al (2006), in tune with the cultures they portrayed (Turkish and Spanish respectively) where perhaps patients with poor functioning may choose to remain at home with their parents rather than live independently. In contrast, the study conducted by Honig et al 1997 (in the Netherlands) included also any “significant other” closely connected to the patient.

The interventions involved family of patients and patients who were in various stages of the illness, for example, in an active manic, depressed or mixed state such as in the studies conducted by Ozerdem et al (2009), Miklowitz et al (2003), Clarkin et al (1990), Miller et al (2004), and Simoneau et al (1999); experiencing a manic episode as in Rea, Tompson, Miklowitz, Goldstein et al (2003) and participants in a remitted mania episode as in Solomon, Keitner, Ryan & Miller (2008), Retzer, Simon, Weber et al (1991) and D’Souza et al (2009).

Unlike the mentioned studies, Reinares et al (2008) intervention included only caregivers of patients in a euthymic phase of the illness.

Format of Interventions

Apart from Retzer et al (1991) and Ozerdem et al (2008), the trials used a standard format of comparing family therapy with other treatments or no treatment or comparing individual family therapy with multi family therapy groups and /or crisis management for bipolar disorder, which emulated standard community care. Patients in the experimental and control groups received pharmacotherapy concurrently to the intervention. However, this was not true for Retzer et al (1991), as it was the only study, where the prescription of drugs happened before and after the systemic family therapy intervention, suggesting that changes at the end of the intervention would not be due to medication, but follow up changes might, if medication was prescribed over this period.

The interventions in the included studies were all experimental interventions, carried out in specialised units, apart from Retzer et al (1991) which was a follow-up study, conducted three years after termination of systemic family therapy sessions. The interventions varied in format and most of the interventions contained specific psychoeducational themes running through them except for Retzer et al (1991). Indeed, five studies by Honig et al (1997), D'Souza et al (2009), Clarkin et al (1990), van Gent & Zwart (1999) and Reinares et al (2008) applied an intervention which was wholly psychoeducational.

Details of each intervention can be found in *Table 2*.

Types of Family Interventions

The family interventions were carried out by professionals from a range of disciplines and with a range of training in family therapy techniques, that varied from little formal training to formally registered family therapists with over fifteen years experience. Similarly, the types of family interventions used, varied between studies as detailed below.

The most commonly used type of family intervention was Family Focused Therapy (FFT), employed by Miklowitz et al (2003), Rea et al (2003), Simoneau et al (1999) and Ozerdem et al (2009). This type of intervention of family therapy for bipolar disorder was developed by Miklowitz and Goldstein (1996) from a previous psychosocial model developed for schizophrenia. FFT consists of three consecutive components: psychoeducation, communication enhancement and problem solving skills. FFT was administered in 21-hour sessions and administered over 9 months following a bipolar episode. Ozerdem et al (2009) reported on the successful adaptation of this type of family intervention in Turkey.

Problem Centered Systems Therapy of the Family, was one form of family intervention adopted by Solomon et al (2008) and Miller et al (2004). This was a short- term, problem focused, manualised family intervention (like FFT) and the focus of therapy was directed towards family functioning, taking into consideration factors such as roles, affective responses and behaviours, communication and problem solving and behavioural control. It was a collaborative approach where duration of sessions and specific problems of the family were determined conjointly by the therapist and the family. Unlike FFT therefore, an emphasis was made to tailor the therapeutic principles towards the individual family and in contrast to FFT, the number of sessions was varied depending on the needs of the family.

Another form of family therapy was the Multifamily Psychoeducational Group Therapy reported in the studies conducted by Solomon et al (2008) and Miller et al (2004). This was a semi- structured manual intervention designed for groups of patients and their families. The sessions provided information about bipolar disorder and coping strategies. Additionally, patients and their respective families were encouraged to share their perspectives about family communication and interactions. This intervention was conducted in 4-6, 90 minute sessions, each session focusing on different topics.

A systemic type of family intervention was employed by Retzer et al (1991). This intervention regarded the family as a living system. It emphasised factors such as individuation in the family, constructions of reality, meanings and attributions, relationships and communication between family members rather than traits or symptoms in individual family members. Unlike other interventions, this intervention was not modified for bipolar disorder patients.

Generally, the psychoeducational interventions were delivered in group settings. Information about the illness and its management and practical advice were given to participants which included patients and their caregivers and/or spouses as in Honig et al (1997), and D'Souza et al (2009), and group sessions for caregivers alone, as in van Gent & Zwart (1991) and Reinares et al (2008). In this type of intervention, discussion between participants was encouraged. Clarkin et al (1990) also used a psychoeducational program in his inpatient family intervention. This was a manualised treatment whose primary goals were acceptance and understanding of the illness, identification of stresses, planning strategies and acceptance for continued treatment after discharge and in the remission period of the illness.

Measures

As can be seen in *Table 1*, the studies employed a variety of different standardised measures along with self-developed measures that have not been validated or normed, such as those cited

in Retzer et al (1991) and Ozerdem et al (2009). This hindered the comparison of results across studies. However, the most cited measures were the Diagnostic and Statistical Manual IV- SCID (Axis I), Diagnostic and Statistical Manual, Global Assessment of Functioning (GAF) and the Schedule for Affective Disorders & Schizophrenia Change version (SADS-C)

Main Findings and Critique of the Included Studies

For ease of readability and comprehension, the findings of studies who employed the same or a similar approach of family intervention are grouped and presented together under the respective heading.

Studies Evaluating Family Focused Therapy (FFT)

Miklowitz et al , 2003

A primary goal of FFT was to foster a greater acceptance of bipolar disorder. FFT used a skills training model to enhance problem solving and communication. Therapists emphasised the importance of clear and constructive verbal and non- verbal communication, for example, maintaining eye contact, showing appreciation.

In this study, patients (N=101) who had experienced an active episode of bipolar disorder (within three months of commencement of the study) were randomly assigned to one of two groups: 21 sessions of family focused therapy (FFT) at home along with pharmacotherapy and a less intensive psychoeducational intervention (2 sessions) with a crisis management intervention with pharmacotherapy. Crisis management emulated standard care.

FFT administered with pharmacotherapy was associated with longer relapse free intervals during two years follow-up. Patients and relatives assigned to FFT showed a greater amount of

positive interactional behaviour following the year of treatment and follow-up. A detailed analysis of the data also revealed that treatment improvements in family communication were closely associated with patients' depressive symptoms suggesting that manic and depressive symptoms may be influenced by different factors which remained undelineated.

A major limitation of the study is that it compares a relatively intensive outpatient home- based family treatment with a much shorter treatment management. Also pharmacotherapy for both groups was administered according to clinical judgement, i.e. was not predefined prior to the commencement of the study, so that treatment effects/ improvement could not be said to have been completely independent from pharmacotherapy effects.

Simoneau et al, 1999

This study examined changes in the face-to-face verbal and non-verbal interactional behaviour of bipolar patients and their families. The sample (N=79) was pulled out from the original population sample (N=101) from the Miklowitz (2003) study mentioned above. Treatments were home based and following treatments, observations of behavioural interactions between patients and relatives were carried out in a laboratory. This study reported that patients and relatives in FFT displayed more positive interactional behaviours than the crisis management (CMNF) condition. The positive improvements in non- verbal behaviours were seen among patients and there was a direct relationship between increases in patients' non verbal behaviour and symptoms' reduction. However, it was notable that following FFT patients' relatives did not show a decrease in negative verbal communication behaviours suggesting that these were not easily amenable to change. It was also noted that patients and relatives were more likely to drop out from the CMNF condition than the FFT condition.

A major limitation of this study is that it could not fully disentangle whether family treatment led to the improvements in patients' non verbal behaviours and subsequently symptoms or whether improvements in symptoms led to more positively toned interactions between patients and their relatives. Laboratory based behavioural interactions may or may have not generated behavioural samples that reflect normal mundane family interactions. The degree to which different mood states could have affected the emotional interactions of the families were not determined. Finally, given that day-to-day mood change or fluctuations is a common place characteristic for bipolar patients, patients' mood changes were only assessed during the months leading to and in interactional assessments but not in between sessions or periods.

Rea et al, 2003

This study included patients (N=51) whose index episode was manic and treatment commenced when they were still hospitalised. Participants were randomly assigned to family focused treatment which consisted of psychoeducation, communication enhancement training and problem solving or Individual Family Treatment (IFT). The individual family treatment consisted of educating the patient, monitoring patient's awareness, crisis intervention and stress monitoring. The findings in this study are consistent with Miklowitz (2003) trial, in which FFT with pharmacotherapy led to longer period of remission prior to relapse. In fact, only 28% of those who had received FFT relapsed during the follow-up period. In this study, the impact of FFT was strongest after completion of the treatment protocol but did not appear during the year of intervention, i.e. when family members no longer had contact with the clinical team. This finding suggested the possibility that some time had to elapse before skills were developed and practiced by families.

As in previous studies, this research suggested that bipolar patients may benefit from the assistance of a knowledgeable social and family system when their own coping strategies are compromised. In fact this research like previous research highlighted that when families are

supported, they are in a better position to support the patient and hence improved management of the disorder. The findings suggested that family treatment appeared to have its greatest impact on those with poorer pre- hospital functioning levels.

A major critique of the study is that there were systematic differences between the two treatments. Specifically, patients in the family focused treatment had two therapists and attended 60 minute sessions. The IFT sessions were conducted by one therapist and participants attended 30 minute sessions. IFT had limited goals and did not focus on family interactions or coping styles of family members. As with previous studies, intervention was limited to patients who were willing to take medication: the impact of a family intervention on medically non-compliant patients cannot be ascertained.

Ozerdem et al, 2009

Participants (N=10) in this study were remitted manic or depressed bipolar patients and their relatives. Following a 9-month period of FFT and pharmacotherapy treatment, patients in this Turkish sample showed increases in Global Assessment of Function (GAF) scores, reductions on the Clinical Global Impression (CGI) scores and reductions in the average number of episodes per year. The study served to highlight that despite the different conceptualisations of family relationships between the western and eastern cultures, there were many similarities in the family responses to FFT.

The study reported that the structured communication and problem solving modules were well received. Relatives were relieved to learn about the origins of the illness. In fact some relatives reported less guilt and an increase in the quality of life. The treatment appeared to improve communication even when expressing emotions was inconsistent with the families' culture. The focus on problem solving also helped establish a template for working together with the patient in managing the illness and ease burden.

A major critique of the study is that although authors put a special emphasis in collecting detailed evaluations from families which served to highlight the mechanisms by which change and improvement were brought about, the small sample size and the lack of control group, make it difficult to conclude that FFT enhanced recovery or prevented recurrences.

Studies Evaluating a Multifamily Treatment versus a Problem Centred Systems Family Therapy Intervention

Miller et al, 2008

The study's main focus was family impairment and its interaction with two forms of family treatment and pharmacotherapy or pharmacotherapy alone. Treatment commenced with ninety-two patients, just after an acute episode. The study highlighted that before implementing family interventions, the level of impairment within the family needs to be assessed. Findings from this study indicated that the addition of a family therapy produced a significant improvement on the course of the illness, when the family was experiencing high levels of impairment as indexed by high Expressed Emotion (EE).

Patients who received either form of family therapy were rated as having half the episodes and spent less time in depression as those receiving pharmacotherapy alone. Another finding was that patients who were assigned to the group family therapy recovered quicker and this was more consistent than the pharmacotherapy group. Conversely, when families were already functioning well, family intervention did not appear to produce significant results.

It is reported that MFT provided a large amount of psychoeducation and the opportunity to interact with other families. IFT on the other hand, did not emphasise this aspect. The difference in consistent outcomes then, suggested that psychoeducation may be an invaluable tool when intervening with families. Whilst families' functioning was improved, sharing and support were also described as one of the most important variable contributing to the treatment's success.

Interestingly, this study highlighted that with high impairment families, greater benefits (outcomes) were registered when level of symptoms were captured or assessed over different times rather than at a single point in time, suggesting that traditional categorical measures may not adequately capture differences between treatment conditions.

A major critique of the study is that sample sizes between the three groups were small, thus results should be considered with caution.

Solomon et al 2008

The authors present the same format of interventions as detailed above in Miller (2008). The study was conducted with remitted manic patients (N=53) and the intervention commenced soon after remission. The overall finding was that neither Individual family intervention (IFT) nor Multifamily Group Intervention (MFT) was significantly superior to pharmacotherapy. However, fewer hospitalisations and pharmacotherapy sessions were associated with MFT. It was hypothesised that this outcome was due to MFT helping families to increase their ability to manage symptoms and mood episodes hence, changing their attitudes towards the illness. Moreover, it was reported that the Multi Family Group treatment decreased feelings of burden and isolation, increased social support and enhanced coping skills for patients and family members.

A major critique of this study is that sample size was comparatively small when considering that participants were assigned to three different groups, thus the power of the study may have been limited. Additionally, the outcome measures used may have not adequately captured factors which were associated with the improved outcomes of MFT, with regards to fewer hospitalisations and need for medication.

Study Evaluating a Systemic Intervention

Retzer et al, 1991

In this study, thirty participants were allocated to a systemic type of family therapy. No control group was used. Of all the studies reviewed here, it had the longest follow-up period (3 years) which consisted of interviews and observations of family interactions. The rate of relapse was considered the criterion by which to evaluate the success of this type of therapy which centred around the communications of the family, helping the family maintain a neutral stance and “softening” the concept of the illness. An overall relapse reduction of 77.59% was reported and improved ratings on family processes such as flexibility of thinking, interaction between family members, individuation, attributions and family atmosphere and quality of life (QoL) were reported. In systemic terms, the therapy helped the family maintain a neutral stance and not get caught up in polarised conflicts.

Perhaps a major limitation of the study was the small sample size (N= 30), however, no drop-out rates were reported. Another limitation was that no formal measures were used, instead ad hoc measures were used which hypothetically captured all the processes mentioned above.

Studies Evaluating a Psychoeducation Intervention

Clarkin et al, 1990

Within the first two days of hospitalisation, participants (N=50) experiencing an acute phase of an affective illness (unipolar and bipolar disorder) were assigned to a standard multimodal hospital treatment and a treatment group of limited sessions of multifamily psychoeducation and the usual hospital treatment. The hypothesis was that a brief family intervention carried out whilst the patient was in hospital, would improve family attitudes towards the patient and towards the treatment, including medication compliance.

At discharge positive outcomes were measured for female bipolar patients, with the better outcomes registered on role functioning. However, by 18 months, this overall effect was attenuated over time, whilst a negative effect was registered for male patients. The authors speculated that the negative effect may have been due to gender differences, i.e. males may have found it harder than women to talk about emotions with their relatives. The unipolar patients were found to have done better with the multimodal hospital treatment. Therefore this study suggested that an inpatient family intervention during an acute phase of the illness was associated with enhanced clinical and role functioning, although this was short-lived. Similarly, families' attitude changes towards the patient and the illness were registered at six months.

A major critique of the study is that at post study, the control of outpatient care was left in the hands of patients and their relatives (so as to mimic a real life clinical scenario) but this could have been an intervening confounding variable. Also, with regard to unipolar patients, it remained unclear as to why a worse outcome was experienced when the family intervention was added to hospital care.

Honig et al, 1997

The hypothesis tested in this study was that psychoeducation would lower Expressed Emotion (EE) levels of key relatives in a treatment group of family based psychoeducation sessions of remitted bipolar patients (N=52) and their relatives, but not in the waiting list condition (no treatment). Findings showed that at 18 months, bipolar patients who had attended the family intervention showed better outcomes. A statistically significant change from high to low EE in family members following the Individual Family Intervention was also registered; clinically this was an important finding as EE is related to poorer outcomes in bipolar disorder, however, the change to reduced EE did not last .

This study shed light on two other aspects such as high EE levels were found to be related to a higher number of admissions. EE levels tended to remain stable for both low and high EE families. Overall, this study highlighted that psychoeducational groups could be promising means to change key relatives' attitudes towards the patient, though EE ratings were shown to be resistant to change over time. The subjective effects reported by patients were them feeling in control over bipolar disorder.

In this study, participants were given the opportunity to evaluate the intervention. Key relatives regarded their participation as valuable as it acknowledged their experience and expertise; an aspect which in the past was reported to have been ignored. A major critique of the study was that one out of the three raters was not completely blind to either treatment conditions and this may have been a major confounding variable, given that EE ratings were central to the hypothetical question underpinning the entire research.

van Gent & Zwart , 1991

In this study, 39 partners were randomly divided into two groups, where the control group was asked to fill questionnaires only and another group of partners of bipolar disorder patients were additionally offered 5 sessions of theme oriented group education.

The therapy was aimed at increasing knowledge of the disorder, medication, social strategies and the aim of the study was to ascertain whether more knowledge of the partner improved well- being of the patient and decreased anxiety. At the end of the sessions both partners and patients reported an increased feeling of well- being and of mutual understanding, however, problems such as marital or sexual problems, loneliness and how to spend time together were still reported.

The study served to highlight that group support was more helpful to educate the partners than individual contact together with the patient. A major critique of the study is that although readmission did not occur in either group of patients, the findings have to be judged cautiously as sample size was small and 71% of therapy patients and 67% of the control group had a job or ran a household independently and without help, implying that most individuals were already coping reasonably well before treatment.

Reinares et al, 2008

This was the first randomised controlled trial of relapse rates on euthymic patients (N=113) or stabilised outpatients. Like the above study, the group psychoeducation intervention was delivered only to caregivers of the patients. The caregivers were randomised into an experimental and control group (pharmacotherapy). The study reported fewer mood recurrences in the intervention group than the control group. It was postulated that the positive impact of psychoeducation might have been its contribution to facilitating an early identification of the first warning signs and consequently an earlier intervention was possible. It was reported that manic prodromes were more distinct and easier to detect than depressive prodromes.

Similarly to Rea et al (2003), an aspect which emerged from this study was the effect of the intervention on recurrences was most apparent during the follow-up period, suggesting that psychoeducation was not merely the transmission of information. Rather it is an active process: a training intervention which requires time to practice the new skills acquired in sessions.

This study served to highlight an important issue: relatives, if trained, may be more sensitive to symptoms than patients. In fact they may be in an ideal position to detect early warning signs of relapse and therefore learn to cope with stressful situations that can act as triggers. Hence, for

any type of family intervention, relatives' expertise and coping skills should not be underestimated and have to be factored in for any intervention to be successful.

Delivering the psychoeducation sessions in group format was found to be effective. It was hypothesised that the group increased support, helped reduce stigma and allowed social networking. It also fostered sharing of information, as well as the discovery of a variety of solutions to problems which were then reinforced by the therapist and members in the group. The group also allowed caregivers to talk about unpleasant feelings which might have been uncomfortable to express in front of patients. Interestingly, some anxiety was reported among caregivers who had experienced a recent onset of bipolar disorder; this was noticed to have subsided as the sessions progressed.

A major critique of the study is that findings cannot be generalised as the intervention was conducted in a specialist centre for bipolar disorder, so results focus on a select and homogenous sample which might not reflect the wider bipolar community. The procedure did not control for the time participants spent with the therapist nor acknowledge the impact of group dynamics on the participants. Hence, the specific ingredients which led to the intervention's success were not fully elucidated.

D'Souza et al, 2009

This was a pilot study which showed that a dyadic psychoeducation program (conducted in 12 sessions) was effective in preventing relapse in bipolar disorder patients, (N=60). It employed a two- group comparison format, where patients were randomly assigned to treatment (SIMSEP) or treatment as usual (TAU), i.e. pharmacotherapy. The program was based on the premise that impaired insight in euthymic patients correlated with poor outcome. The reason behind this program was to put an emphasis on sharing and accepting the responsibility to maintain

wellness. This also entailed giving permission to the companion to intervene when insight was compromised should there be a relapse.

This program fostered a collaborative approach by empowering a trusted figure to intervene early when symptoms may have appeared to have compromised the patient's awareness. It was found that hypomanic/manic symptoms were significantly decreased in the SIMSEP group than the TAU group. This difference between treatment groups however, was not registered for depressive symptoms, perhaps because manic symptoms or prodromes were detected more easily by companions. These findings were consistent with Reinares et al (2008). Another reason in explaining this difference in relapse rates was that improved medication adherence was registered in the SIMSEP group.

A major critique of the study is that sample sizes were small. Additionally, improved outcomes could be said to have been, in part due, to greater medication adherence. Nonetheless, this study served to highlight that giving permission to a companion to intervene, in case of relapse, may be an emergent key property for dyad/ companion based programs in the prevention of bipolar disorder.

Discussion

Despite the various methodological differences in the included studies and family approaches employed, some tentative conclusions can be drawn.

Retzer et al (1991) was the only study in which medication was prescribed before and after family therapy, not during therapy, thus strongly suggesting that the changes observed in the follow-up period, were not to be explained by the effects of medication. Despite the methodological limitations as stated above, this study has been included as NICE (2007)

advocates for the inclusion of such studies when the findings are consistent with the remaining body of evidence.

The studies reviewed here, employed a number of different approaches to family therapy. Overall, however, these studies suggested that family interventions for bipolar disorder benefit family members and patients, although some studies reported higher success rates than others such as Retzer et al (1991) and Miklowitz et al (2003).

Family treatment sessions varied in intensity and duration. For example Miklowitz et al (2003) used an intensive 21 home based intervention of FFT whilst psychoeducational treatments tended to be shorter in duration, particularly interventions following a multiple group family interventions (MFT) such as 6-10 sessions in Miller et al (2008) and 6-12 sessions in Solomon et al (2008). It is hypothesised that these interventions were just as successful because families were allowed to interact with each other and this could have eased burden and isolation as well as increase their social network and sense of agency.

All of the studies included some form of psychoeducation, some stressing this component more than others. Qualitative feedback from all studies highlighted the appreciation of the material presented. This was a consistent finding which suggests that even though carers may have been involved for a long time in the patients' care, they still appreciated the educational input. Other modes of treatment should offer family psychoeducation as an integral part of psychosocial intervention.

Another aspect which emerged in this review is that three studies Clarkin et al (1991), Rea et al (2003) and Simoneau et al (1999) initiated their treatments whilst patients were not yet fully

stabilised unlike the other studies reviewed here. This suggests that when employing family interventions, these could be initiated while the patient is in an acute phase of the illness.

Additionally, it is likely that bipolar patients and their families are agreeable to a psychosocial treatment in the midst of a crisis. This may prevent treatment refusal when the acute symptoms may have remitted.

A number of standardised outcome measures have been used in evaluating the effectiveness of family therapy, including SCID, GAF and SADS-C, however, these showed mixed results. It is hypothesised that these measures do not fully capture the processes involved in recovery. Only the studies by Retzer et al (1991) and Ozerdem et al (2009) tried to capture other variables such as improved quality of life. In the future, studies should focus on including process measures to detect the active mechanisms associated with improved outcomes and quality of life measures for patients and carers alike.

Furthermore, most of the studies reviewed measured mood only at the point of intervention and after the intervention. Given the fluctuating nature of moods in bipolar disorder, in any intervention moods should be assessed more often. For example, mood should be taken at the beginning of each session as this would have an impact on the person's level of engagement with therapy. Also, it was noted that family members' moods were not measured. It is hypothesised that due to the level of burden experienced by carers (Reinares et al, 2004), anxiety and depression would be a common feature in their experiences. It is suggested that mood measurement should be considered for carers, so as therapy progresses, changes in mood could be one mode of determining whether the family intervention is having any impact on depression and anxiety exhibited by carers and whether these states affect the emotional tone of the family.

Although all treatment modalities emphasised collaboration between the patients and their caregivers, only the studies by Honig et al (1999) and D' Souza et al (2009) introduced and stressed the importance of accepting mutual responsibility for the management of bipolar disorder. Therefore allowing carers to have understanding for the patients' illness when insight is lost in an acute phase, may possibly help to identify prodromes and triggers early so that the ascent into mania is avoided thus shortening relapse time or avoiding relapse altogether.

Accordingly then, family interventions were shown to impact on families and familial processes though changes in EE could be short-lived. To summarise, family interventions contributed to increasing knowledge which helped increase sense of control and agency (van Gent et al, 1991 and Retzer et al, 1991), acknowledged and supported caregivers in their experiences of managing BD, (Honig et al 1997 and van Gent et al, 1991) and empowering the family to intervene early (D'Souza et al 2009). The outside support offered by family intervention also helped ease burden of family members as reported by Miller et al (2008) and Solomon et al (2008). Family interventions also contributed to emphasising collaboration (Honig et al, 1997 and D'Souza et al 2009) and helped to improve families' attitudes towards the patient with BD (Clarkin et al, 1990, Retzer et al, 1991 and D'Souza et al 2009).

After intervention, families learned new skills in managing BD, (Miklowitz et al 2003, Simoneau et al, 1999, Ozerdem et al 2009 and Rea et al 2003) problem solving (vanGent et al, 1991 and Reinares et al 2008) and displayed more positive verbal (Miklowitz et al, 2003, Clarkin et al 1991, Simoneau et al, 1999 and Ozerdem et al, 2009) and non- verbal interactions such as affiliative behaviours like making eye contact and leaning towards the family members when speaking (Simoneau et al, 1999). These findings are a continuation of Honig et al's (1997) findings which showed that family interventions attenuated EE levels, although the effect was short-lived. Former studies did not measure EE ratings but in future research it would be helpful to include EE ratings so as to identify and verify any correlations between the two. Finally, it

helped families tolerate ambiguity and ambivalence as well as increase their sense of autonomy and individuation Retzer et al (1991) and bring about a change in role functioning (Clarkin et al, 1990).

Clinical Implications

The current review lends support to the nascent literature on the role of family intervention in the comprehensive outpatient management of bipolar disorder. The studies reviewed here showed that a family intervention could be initiated while the patient is still symptomatic. Positive effects on family processes such as psychosocial functioning and roles within a family unit were reported and family interventions helped families understand and in turn help patients in a crisis and were a useful source of support. However, little is known how changes in family processes alter a patient's vulnerability to the illness. Therefore, the impact of these treatments require further study to help elucidate underlying mechanisms.

Research needs to consider the barriers to implementing family interventions as part of a comprehensive outpatient management of BD, given the findings reported in the studies reviewed here, that rehospitalisation rates (perhaps the most costly of treatment options) decreased after family interventions. For example, the addition of a multifamily psychoeducational group intervention appears to be very efficacious and cost- effective in terms of time and resources. Furthermore, future treatments should look at empowering families to share their expertise with other families as is currently advocated in the self management programme by the Manic Depressive Fellowship.

Family treatments assume that families or caregivers would be willing to participate in the treatment sessions. This may not be necessarily true and it may be useful to determine whether there is an appropriate time point at which to approach families. For example, some studies

reported refusal and drop- out rates. It is suggested that when this happens, the reasons behind refusal to participate or to continue treatment should be investigated and discussed with the family.

Finally, patients with bipolar disorder who have spouses or a close family may only represent a section of the wider bipolar population as the strain of symptoms imposed on relationships may indeed alienate patients from forming or keeping close relationships, so although family interventions are effective, its wider application may be limited by this consideration.

Conclusion

To conclude, the research evaluating a diverse range of family interventions suggested that both patients and families benefit from these interventions, especially patients may benefit from the assistance of a knowledgeable and supportive social network. The differences in treatment aspects, patient samples and timing of treatments do not allow for an easy identification of the reasons or the differences in the overall efficacy of family treatments, however, these proved successful in changing family processes. More research is needed to help uncover the mechanisms underlying the impact of family interventions on family processes.

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Empirical Paper

The Experience of Different Types of Mania in Bipolar Disorder

An Interpretative Phenomenological Analysis

Abstract

Background

Previous factor analytic studies theorised about the existence of different types of mania which seemed to be characterized by different profiles. There seemed to be an implication that persons with bipolar disorder would act in accordance with the prevailing dimensions or symptoms present as dictated by the type of mania experienced. This study explored the personal experiences of people suffering from bipolar disorder and mania.

Method

A semi- structured interview was used to interview seven participants on their experience of living with different types of mania. The transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results

A total of five superordinate themes emerged from this study, providing one interpretation of the experience of different types of mania in bipolar disorder. Themes related to factors making the experience chaotic, making sense and managing mania, themes related to sense of identity, awareness and recovery were identified.

Conclusions

The identified themes are discussed in relation to existing literature on bipolar disorder specifically, the manic experience. Clinical implications of the findings are outlined and methodological limitations and areas for future research are discussed.

Introduction

Bipolar disorder is a treatable and serious illness marked by extreme changes in mood, thought, energy and behaviour. It occurs with equal frequencies in the two genders. It usually begins in late adolescence and young adulthood although it can start in childhood and later life. The knowledge of a blood relative who has mood swings or is known to have suffered from bipolar disorder puts an individual at a high risk of developing the illness (DSM-IV). But the mechanism of how the disorder is inherited is not yet understood (Goodwin & Jamison, 1990).

According to the American Psychological Association (1994), mania is the defining feature of bipolar disorder. Mania is usually described as an abnormally and persistently raised expansive or irritable mood. The difference between mania and hypomania is one of degree of severity, mania being more severe, more prolonged and more debilitating in nature. In a study by Kessing, Agerbo and Mortenson (2004) conducted on a total of 1565 patients, an association was found between onset of mania and stressful life events. Additionally, a recent redundancy, a recent divorce and a recent marriage were also moderately linked with the onset of mania. This study also suggests that this susceptibility to develop mania when faced with a stressful life event seemed to remain unvaried during the life span, for both genders.

In another study by Johnson and Miller (1997), it was established that people with more severe histories of mania reported more negative life events. Furthermore, life events associated with goal attainment predicted increases in manic symptoms. Indeed psychological and social factors may play a much larger part in the course of the illness. This study also found that persons with severe negative life events took more than three times as long to recover as those without these severe experiences.

The cognitive model for bipolar disorder hypothesises that a range of behaviours such as goal seeking behaviour, extraversion and achievement strivings over time, could be linked to increased manic episodes in patients with bipolar disorder (as cited in Lam, Wright and Smith 2004). In relation to this, Johnson, Cuellar, Ruggero, Winnet- Perlman, Goodnick, White and Miller (2008) conducted a prospective study on 125 individuals and found that goal attainment life events predicted increases in manic symptoms and tended to predict depressive symptoms in patients. In another study conducted by Lam, Wright, and Smith (2004), it was postulated that extreme goal striving attitudes in bipolar patients may be brought about by dysfunctional beliefs that lead to extreme goal attainment.

In a study conducted by Lam and Wong (1997), bipolar patients were able to identify prodromal symptoms. In this paper it was reported that mania prodromal phase seemed to be characterised by more behavioural symptoms. Common symptoms include psychomotor activation, co-morbid depression and anxiety simultaneously present at any one point, better known as dysphoria, an increased hedonic tone, irritability, aggression and psychosis. Aksiskal and Benazzi (2001) suggested that mood in bipolar disorder should be specified as elated, depressive, anxious or irritable. Moreover they asserted that psychomotor activation should be considered as a stem criterion.

In a factor analytic study by Cassidy, Murray and Carroll (1998), five core factors or dimensions of mania were analysed. These were namely, dysphoric mood characterised by lability and anxiety, psychomotor activation characterised by increased activity, racing thoughts, poor concentration and pressured speech, psychosis which represented the third factor and hedonia. This factor comprised a euphoric mood, humour, increased sexuality and grandiosity. The last factor analysed was irritability.

More recently in a study conducted by Gonzalez Pinto, Ballestros, Aldama, Perez de Gutierrez, Mosquera and Gonzalez-Pinto (2003), the five dimensions described above were compared for manic episodes and mixed episodes. Hedonism and psychomotor activation were found to be typical of a manic episode but appeared to a lesser extent in a mixed episode, however, the dimensions of dysphoria and psychosis were similar for both. The same authors also argue that the existence of a depressive dimension in mania remains contentious.

In a recent review paper by Pedley and Mansell (2008), they asserted that people with bipolar disorder may in effect experience discrete categories of mania where depressive mania is identified by its depressive features. As can be deduced psychotic mania is characterised by psychosis and pure mania or euphoric mania (perhaps the most recognized form) is a classic acute manic state with euphoria and grandiosity. Finally, dysphoric mania is usually characterised by irritability, crying, helplessness and suicidal ideation

In trying to define the structure of the lifetime mania-hypomania spectrum, Cassano, Mula, Rucci, Frak, Kupfer, Oppo, Calugi, Maggi, Gibbons & Faggiolini, (2009) used 69 items of the Moods- SR questionnaire. When item response theory based factor analysis was used, the factors which were confirmed included psychomotor activation, mixed instability, spirituality, mysticism/ psychoticism, mixed irritability and euphoria. The study also supported the definitions of pure mania which is seen to be characterised by psychomotor activation and euphoria and mixed mania characterised by mixed instability and mixed irritability.

To recapitulate, mania and hypomania seem to lie on a continuum. Cassano et al (2009) confirmed psychomotor activation as one of the principal components that characterise both mania and hypomania. Stressful life events and extreme goal attainment have been linked to the onset of a manic episode (Kessing et al 2004, Johnson & Miller 1997, Johnson, Sandrow,

Meyer, Winters, Miller, Keitner and Solomon 2000 and Lam et al 2004). Psychological and social factors seem to be important factors in the onset of a manic episode and may play a much larger role than attributed to them (Johnson, Ruggero & Carver, 2005). Dysregulation of daily function in association with dysfunctional beliefs seem also to impact on the course of the illness and onset of mania (Lam et al 2004 and Wright et al 2008). A particular cognitive style, characterised by a lower self esteem, a greater negative evaluation and a lower positive evaluation of self, a greater need for achievement and a greater need for dependence and acceptance from others seem to characterise the affective disorders, in particular bipolar disorder (Jones et al 2005). Manic prodromes have been shown to be identifiable by patients. When behaviour strategies were adopted, these helped patients experience a better prognosis of the illness in the form of less relapses of manic episodes (Lam et al, 1997).

In the review by Pedley and Mansell (2008) presented here, core dimensions were used to discretely categorise mania into different types. In theory as well as in practice, this could potentially have resounding effects on how people with bipolar disorder are identified and managed clinically throughout their lives for a number of reasons. The different types of mania seem to be characterized by different profiles. There seems to be an implication that persons with bipolar disorder would act in accordance with the prevailing dimensions or symptoms present as dictated by the type of mania. For example, one would suppose that the sense of self esteem would be different for a person who is going through a euphoric or “happy” mania to someone going through a dysphoric or “uncomfortable” mania. Similarly, life experiences would be evaluated differently for a person going through a depressive mania in comparison to when the same person would be going through a pure mania. Patients often report that they have experienced these different types of mania in the course of their illness (Lam 2008, Personal Communication).

The clinical relevance of research in this area is the potential for findings to contribute to the understanding of how patients experience different types of mania. It is envisaged that persons with BD would be able to recall different coping strategies, or pursuing different life goals in accordance with the symptoms prevalent in a particular type of manic episode. Indeed these differences could be described and made sense of differently within the same personal experience. Since bipolar disorder is a lifetime disorder, it is envisaged that persons with bipolar disorder could be able to distinguish different periods of manias characterised by the different symptoms and recall different life events associated with any one type of mania.

The aim of the study is to look at people's experiences of different types of mania. Indeed, clinicians have long been aware that experiential data are vital to an understanding of individuals and their illnesses. The primary long-term treatment for bipolar disorder is usually medication but psychological interventions have an important part to play as well. If these different types of mania were to be recognised, then from a psychological standpoint, in the future, therapy may be modified and used to address the unique needs of the individual person at any particular point in time.

Method

Design

A qualitative design involving a semi- structured interview was employed for this study. These interviews were then analysed using Interpretative Phenomenological Analysis. This is an idiographic and thematic approach which involved analysing each participant's account individually before attempting to find similar themes in the different cases studied.

Underpinning this type of research is the assumption that people interpret their experience so as to make sense of it. Therefore this study explored the sense that each participant made out of their experience and the meaning they gave to the experience (Smith 2003). This was

considered an appropriate method to use as the aim of the study was to look at participants' experience and perception of differences between their manic episodes.

Typically qualitative research is not concerned with seeking a definitive truth but rather the stance is one of exploration. Moreover, the researcher's influence is acknowledged and accepted as integral to the research process. This is described as a "double hermeneutic" (Smith, 2003) as the researcher is drawn in the process so as to make sense of the participants' experiences or their perceptions.

Recruitment

A criterion sampling approach was used to select participants for the research.

Procedure

First ethical approval was sought and granted from the Local Research and Ethics Committee. Following this, the researcher contacted the three local Community Mental Health Teams to help with recruitment of participants. The teams were briefed of the study and information and consent sheets (see Appendix D) were distributed to them as the potential participants were initially approached by their Community Psychiatric Nurse to inform them about the study. The participants who were willing to take part in the study were asked to contact the researcher who invited them to the interview.

At the interview, the researcher outlined what the interview would entail, went through the information sheet and clarified points raised by the participants. The participants were asked to indicate that they had agreed to participate in the study by signing a consent form prior to the administration of the measures. Potential participants received a structured clinical interview, SCID- Module A, to assess for a history of bipolar disorder. This was the main inclusion criteria. They were also screened using the Mania Rating Scale (Bech et al 1978) and the Beck Depression Inventory (Beck et al, 1961) to make sure that at the time of the interview, they

were not experiencing a manic or a depressive episode as any participants in an active phase of the illness would have been excluded from the study.

Participants

All participants were screened and were found to meet the inclusion criteria. Seven participants took part in the study as recruitment difficulties were encountered, however, it was felt that data saturation had been reached at that point. Six were females and 1 was male. Four participants reported not having experienced mania for the past five years. One participant has not had a relapse since ten years another lady experienced a relapse in August last year. The gentleman reported having had the last episode approximately a year ago.

Measures

1. *Structured Clinical Interview for DSM-IV- Axis I* (SCID-I; Spitzer et al, 1992).

The SCID-I was devised from the DSM-IV Axis I. Interview questions correspond with diagnostic criteria for the Axis-I disorders. For the purpose of this study only the part related to affective disorders was used which can identify individuals who should receive a diagnosis of mania, major depression or hypomania. The researcher was trained in its administration.

2. *Beck Depression Inventory* (BDI; Beck, Ward, Mendelson, Mock and Erbaugh, J, 1961).

This is a self report measure. It measures depression in people over 16 years of age. Developed from the Cognitive behavioural perspective, it taps into the cognitive, behavioural and physical aspects of depression as experienced in the recent past or “over the last week”. Participants who scored more than 15 on this measure were excluded from the study.

3. *Mania Rating Scale* (MRS: Bech, Rafealsen, Kramp and Bolwig, 1978).

The MRS is an 11-item, observer-rated scale relating to common manic symptoms. Each item is rated on a five-point scale. The MRS has been found to have good reliability and validity. Only participants who scored less than 5 on the scale were included in the study.

Data Collection

Data was collected by the main researcher. When the relevant paperwork was completed and all the inclusion criteria were seen to be met, the researcher conducted a semi- structured interview (see Appendix E) which helped participants give a picture of their lived experience. The questions tried to capture participants' experiences of different types of mania, factors and triggers that preceded each mania type and its progression, life events and coping strategies.

The duration of the interviews varied and ended when the participants had nothing to say and all the areas of enquiry were covered.

Data Analysis

Data analysis occurred following the completion of the interviews. The transcripts thus collected were subjected to IPA. This entailed various levels of analysis (Smith, 2003). The transcripts obtained were re-read several times until there was a thorough understanding of the text. Comments and reflections about the text were noted down. The right hand margin was then used to record potential themes which were analysed and then clustered according to relations between them. The emerging themes which were found to relate to each other were drawn together. These clusters were then labelled using a super-ordinate theme. These themes were then checked with the transcript so as to ensure that that the real meaning was grasped.

A summary table was produced which highlighted the stronger themes and helped to discard the less prominent ones until the final themes offered a good representation of the phenomenological experiences. An example of data analysis using an extract from an excerpt is provided in Appendix F.

Validation

Whilst working on the project, the main researcher was mainly concerned with the participants' social life and experience including discourse rather than trying to capture an accurate interpretation of the truth. In essence, the focus of the study was the participants' own experience. To meet this aim, the research process required the author to adopt a reflexive attitude by being vigilant about her values, interests and assumptions and the role that these played on the research process. In fact, the iterative approach used, whilst checking transcripts for evidence to support the emerging themes was constantly underpinned by an awareness of the author's positioning in the research process. These reflections were entered into a diary and discussed with the second author.

Quality checks are also used in IPA to make sure that the findings are valid and rigorous. To ensure this, the second author conducted a mini audit of the emerging themes by reading a random selection of the transcripts so as to ensure that there were no discrepancies and that there were clear links between the text and the author's interpretations of it and that this understanding was presented in a "coherent, data- based /narrative framework" (Elliot, Fischer & Rennie, 1999, p 223).

Results

Whilst accounts differed on some levels, the convergence between accounts was striking as most elements were shared across participants. The themes that emerged were relatively unconnected to the questions asked resulting in a change of emphasis from the experience of different types of mania (main research question) to a much wider experience of living with bipolar disorder. An explanation for this happening was that as participants were given free rein as to what they chose to speak about, they were allowed to bring their own understanding of the experience (in keeping with the philosophy of IPA) and possibly highlighting the reality that the

participants' understanding of mania is not merely that mania is a defining feature of bipolar disorder (APA, 1997) but indeed, when they talked about mania they were talking about bipolar disorder and vice versa.

On analysis, the commonalities between different types of mania (which often occurred within a single episode) came out more strongly than the differences and the emerging themes reflected more accurately peoples' experience of mania and bipolar disorder as a whole. A total of five superordinate themes were identified, composed of minor or subordinate themes. A summary of the themes is presented in *Table 1* below.

Table 1. Summary of superordinate and subordinate themes.

Superordinate themes	Subordinate themes
Chaos versus control.	Unpredictability of mania: Unstoppable Fleeting and changing thoughts Shame & Guilt Psychomotor activation versus Exhaustion Control
Making sense and managing mania.	Ambivalence (towards mania and medication) Wanting to make sense and understand the phenomenon Coping
Sense of Identity	Fluid sense of self Self in relation to others
Awareness	Becoming aware of the dangers of mania Bringing in Significant Others' awareness when own awareness is missing Need for increasing Awareness
Recovery	Compassion and Acceptance Growth and Wisdom

Themes will now be described in more detail.

Chaos versus Control.

The first superordinate theme related to factors that made the manic experience chaotic. This theme comprised six further sub-themes.

Unpredictability of mania

The most conspicuous theme was the unpredictability associated with mania. Participants talked about having lived through different experiences of mania as the experience mutated within the same manic episode. For example,

“A lot of it seems depressing and a lot of it then very high suddenly..Ehm delusions of grandeur and stuff but considerably the opposite sort of thing, quickly turning around within the same episode, even within the same hour or whatever” (*Participant 3, line 10-14*).

“Well there is mania where there is energy to create which is very exciting and then there is mania which is dangerous and then there is mania that becomes religious..this comes so high! (Participant 4, line 11-16).

Each manic episode was experienced differently.

“No two are the same. There’s definitely different ones. It can go for a couple of days and it can go on for weeks...You can be happy manic and that’s when you need to talk to people. Then there’s the angry one, you’re energetic but angry all the time” (*Participant 6, line 28-30*).

The experience was that mania progressed from one state to another, for example, “I would get really sad and cried and cried and that went on for days and then I came out of it. And then I was extremely active”. (*Participant 5, lines 29-30*).

Participants also described an interplay between mania and how people around them reacted to them when in mania, for example:

“I became obsessed, deluded that this man loved me. My heightened sexuality ran away with me and I just ended up in cuckoo-land (*Participant 2, line 92*).

Participants described that although they could recall that there were differences between the manic episodes, in time, these different experiences seemed to have merged into each other.

“It’s hard to tease one out from another because when you had way over ten, you lose count and you lose what has been happening in them” (*Participant 3, line 104-105*).

Feelings of terror were sometimes associated with mania, making participants loathe the experience.

“But then it can be really frightening. And people. I bet people may say, I love the manic bit. But no” (*Participant 7, lines 120-121*).

High levels of stress also featured in the participants’ experience of mania, which tended to cause extreme anxiety. Some participants reported having used alcohol or medication to relieve the tension or numb the experience, for example

“The last time I was in hospital, they gave me *Diazepam* so that my muscles would relax...I was so anxious by it and my stomach. I just used to throw things up and it wasn’t me putting a finger down my throat. So it was anxiety, so that was why”. (*Participant 7, line 174-179*).

Increased vulnerability while in mania was noted by all participants, where participants described having put themselves in risky and possibly dangerous situations.

“And I would say that more has to be looked into..how people could get into trouble physically when they are manic” (*Participant 4, lines 425-426*).

It was not uncommon for participants to experience an increased sense of empathy while in mania. “Usually with mania you get empathy and you’re happy with it and you find it really hard to say no to people. You can be really manipulated”. (*Participant 6, lines 153-154*).

Unstoppable

“ But when you’re manic, when you actually get into a full mania, you cannot stop it” (*Participant 4, line 81-82*).

A common experience shared by all was that, once started, mania could not be reverted; it had to run its course. Participants said that they were sometimes able to recognise a mania onset but could not revert its course. As they became more drawn into mania, they reported finding it hard to talk to professionals about their manic experience or merely explain how they felt.

“There was no way back for me. I couldn’t sit in a doctor’s office, I couldn’t talk and explain, ‘Look I am getting ill and I need this and I need that’ because I was too drawn in” (*Participant 4 262-263*).

Even when professional help was sought promptly, the medication did not always help. Thus when mania became unmanageable, it was common for participants to talk themselves through it and find consolation in knowing that it would eventually subside.

“I would say ‘You know, I’ve been like this before and I got better’. It was just like ‘Oh, just hold on until you feel better’ because I know I will ”(*Participant 7, lines 340-342*).

Fleeting and changing thoughts

Another common theme was the fleeting and changing thoughts which made the experience contradictory and confusing. Participants described feeling pressured to follow these thoughts through.

“It’s like something against you and there is so much confusion around you. All the sort of ideas that come to my head, that are plans to deal with things and do things. It’s like a beast”

(Participant 3, lines 7-8).

Participants were concordant that these thoughts usually were out of character for the participants when not in a manic episode. In retrospect these thoughts were experienced as irrational

“I just thought that someone would climb through my windows. I was terrified that when I got back, there would be three blokes here. Where did that come from, you know?” *(Participant 7, line 154-155).*

Participants also mentioned that their thinking was affected.

“You refuse to go into things. It is quite a dangerous frame of mind”.*(Participant 6, lines 417-418).*

Shame and Guilt

“The absolute paranoia. Oh my God, what have I been doing? ..Is so debilitating.”*(Participant 7, line 558-559).*

Shame and guilt also featured in the participants’ experience of mania. These would usually set in after the manic episode had subsided, at times sooner, during the recovery period. As participants become less drawn in mania, they started to make sense of their experience, which was described as humbling.

“picking up the pieces afterwards was.. there is so much humility involved. *(Participant 2, lines 52-53).*

This was experienced as unpleasant and social support was invaluable in helping participants overcome these uncomfortable feelings.

“Usually when I come out of hospital and into decline, I feel so ashamed of the things that I have done. But I have had good CPNs who helped me not feel that way.” (*Participant 4, lines 115-117*).

However, at times participants were aware of the inappropriateness of behaviours and isolating oneself was mentioned as a way to avoid embarrassment.

Psychomotor activation versus Exhaustion

The experience of psychomotor activation was that it was inextricably linked to exhaustion. Participants described grappling with psychomotor activation and exhaustion as a difficult reconciling task. The psychomotor activation experienced in mania usually led to exhaustion but the reverse was also true and participants could not explain the interface between the two as explicated by this participant:

“But basically, I go against the grain because my body and mind are so exhausted, so you’re fighting it, you know”. (*Participant 4, lines 256-258*).

Looking back, it feels like strange that you have this power after being so exhausted” (*Participant 4, line 178*).

Participants were not able to stop themselves even when taken over by mental and physical exhaustion, however, exhaustion eventually took the better part.

“Once after about a week of running in the streets, I was too tired to continue. Then my sister found me in Scarborough” (*Participant 1, lines 99-100*).

Control

Feeling out of control and wanting to take control during a manic episode was another theme mentioned by participants. Although mildly activated states were seen as rewarding, participants

realised that this state could lead to a “full blown” mania, which then became difficult to control. Cutting down on or avoiding activities that could bring on an episode was described as one method of regaining control. This was a difficult process which highlights further the conflict that mania creates;

“Yeah..I am a lover of life but this, cause I’ve been told that the mania and I’ve been in hospital quite a few times and I know that I have to control it because I don’t want to go down again. You know when I was told people live like that and I love it..But I can’t love going too high anymore because it’s too destructing, on everyone. You kill yourself. (*Participant 4, lines 60-64*),

This quote highlights the destructing and distressing nature of the manic experience for themselves and those close to them. In time, however, with experience and the knowledge gained of the manic episodes, it became easier to control the ascent into mania.

“Ehm.. just over time I am able to control that, as if, ehm..it’s a control, as if the brakes are on. You know if I am in a situation where I know I need to come down a bit, cause I never ever go up there now or down there now. So if I am in situations where I am staring to escalate a bit, then I won’t” (*Participant 7, lines 222- 226*).

Making sense and managing mania

Making sense and managing mania was another major and superordinate theme in the interviews. Making sense of the experience required managing the ambivalence towards the manic episodes as well as the much needed medication. It also involved making sense of the experience, accepting it as part of an illness and recognising triggers and factors which led to mania. Developing coping strategies to counteract and avoid mania was another theme under this heading.

Ambivalence towards mania

Ambivalence was common in participants' accounts of the manic experience.

“Exhilarating, energetic, amazing, horrifying and terrifying. Anything like that really, just at both ends of the spectrum. And just little in between, varying from one extreme to the other.
(Participant 3, lines 138-140).

All participants described mania as living between extremes, like being on a “roller coaster” ride. Although mildly activated states were described positively and were linked to enjoyment, creativity and productivity, compensating to avoid experiencing mania was evident in participants' accounts.

“I always pre-plan now. Monday and Sunday, I was a bit energetic and I said ‘Right I am going to do such and such till three o’clock and then I am going to sit down and watch a film’
(Participant 6, line 553-554).

Medication

Although medication was the first factor mentioned, in maintaining wellness, however, it was another topic of ambivalence as illustrated in the citation below;

“Ehm..felt that, between us, we thought that I could manage with drinking when I wanted to and with proper psychotherapy, I would be able to handle my lows and highs without medication”
(Participant 4, lines 279-281).

For some participants, this reticence toward taking medication was due to not accepting that they were ill or finding the side effects aversive. Only with time came the realisation that it could not be managed without the medication.

“When you get that bad enough, you will listen to the doctor and you will take your medication”
(Participant 6, lines 146-147).

In their experience, participants stated that some time had elapsed before the right combination of medication was found as they were resistant to the medication or the medication was inadequate

“The last time I was high, I said ‘I can’t do this anymore. I can’t keep being in and out of hospital and stuff’. I just wanted it to end. So just luckily, that it was- ‘We think it’s this, we’ll try this and we’ll get you on this medication’. Because then I thought, they must be giving me medication that goes with the illness.” (*Participant 7, lines 113-118*).

Wanting to make sense and understand the phenomenon

After having experienced mania, participants sought to make sense and understand the phenomenon.

“I do try to work something out really and I put quite a bit of effort into that” (*Participant 3, lines 322-323*).

Making sense entailed seeking information and knowledge from professionals and it also involved sharing the experience with close others and seeking their opinions. Identifying triggers and factors which led to mania formed part of this process.

Coping

All participants identified stressful life events as having triggered the onset of mania. The most commonly cited stressful life events were bereavement, divorce, death of close relatives, birth of own children and sexual abuse. Achievement was not linked to the onset of mania. Various factors that maintained the manic experience were also identified by the participants.

“Some stressful events happened and triggered it off and the rest of it was me not looking after myself, you know, not very well and medicating myself with cannabis and alcohol.” (*Participant 7, lines 198-200*).

During a manic episode, participants reported little resources to cope with mania apart from following the pharmacological regime. Coping strategies were developed later after the manic

episode would have subsided. Finding ways of coping was described as an individual process and usually required lifestyle changes. For example, despite wanting to be around people, some participants described keeping away from social situations so as to avoid mania.

“I am not going to pubs and clubs where I could you know, meet the wrong people, you know do drugs in that environment, stimulating environment. People do clash you know, when you’ve had a few, so you are not in the right environment. So I keep away from that side of stuff and anything that could cause me anxiety or stress or get me in a sticky situation.” (*Participant 7, lines 514-519*).

Participants reported that once they were feeling better and coping better things progressed and they started recuperating lost skills and pursued activities which they would not have been able to do whilst in the grip of mania.

“I suppose I am dealing with things more now, not letting them build up. So the tablets helped me. The change in medication has really changed my life. Yeah.. and one thing leads to another. I do simple things and I get to a platform and when I get there I can do anything. I can do things. Like looking after my diet and cut down on smoking” (*Participant 2, lines 282-286*).

Sense of Identity

Another superordinate theme which clustered in the data is the impact that mania had on their sense of identity.

Fluid sense of self.

Participants described how mania influenced their sense of self in different ways.

“What is me? Is this me? (*Participant 6, line 102*).

Participants expressed a sense of disbelief at being told that mania was an illness. For the majority of participants, the experience of fluctuating moods had been part of their lives, since their early and late teenage years as exemplified by:

“ And..I have always been the type of person where I can be quiet and noisy. Do you get what I mean? So mania would..I’ve always been a night person and I’d stay awake at night. I suppose in my youth I was manic but I didn’t..Nobody ever said anything to me and I just didn’t know any different” (*Participant 5, lines 98-100*).

In many cases, confusion arose for participants in trying to differentiate their sense of self from the manic episodes;

“Well when somebody says to you, you’ve got bipolar, this, this and this, it strips back everything. It is this..looking at yourself and thinking ‘When I did that or said that, was that the mania, or was that me?’ What is me?” (*Participant 6, lines 98-101*).

Conversely aspects of the manic episode were incorporated in their definition of themselves and it was hard to differentiate mania from personality traits, for example;

“I used to resent the fact that if I danced on the table, at a party and I wasn’t drinking, people would say ‘How is she gonna drive home?’, you know. Yet I was dancing on that table because I was happy but that is me. So what is me and what is mania is very hard to tell. (Participant 4, lines 54-57).

As in the above example, there was a realisation that the sense of acting self was actually created within the context of a particular manic state. This was described as demoralising and feelings of unreality ensued, for example

“It’s like I’ve been feeling unreal. That could not be me and I came through it with feelings of non- reality. Do you understand what I mean?” (*Participant 5, lines 222-223*).

Self in relation to Others

The experience of self in relation to others was another theme explored by participants. At times, there was an awareness that others were embarrassed by their behaviours.

“I mean I was terrible, so embarrassing when I think back on it. B. was just devastated and we left the party”. (*Participant 4, lines 121-122*).

Mania was experienced as a time of vulnerability and participants were compelled to protect themselves and as a result were very careful and selective of the choice of people to confide in. This circle of people was usually reduced to a few intimate friends and family. However, at other times, participants concealed their experience even from these people, as they did not want them “to see” the full impact that mania was having on them.

“Somehow you don’t always want to tell your family, you know. You’re always in tears and you don’t want to show your husband that you’re unhappy. That’s the awful bit about pretending again.” (*Participant4, lines 364-366*).

Participants felt that mania was a unique experience, incomprehensible to people who do not experience it. Feeling different to people who have not experienced mania was tied to this aspect.

“I forget what M. says but it is sort of.. like being on a different frequency to people who sort of don’t have the mania” (*Participant 3 lines 500-501*).

Awareness

Another superordinate theme identified in the data was awareness. It encompassed three components: becoming aware of mania, allowing significant others to have insight when their own insight was impaired and general awareness tied to public and professional awareness.

Becoming aware of the dangers of mania

Until their diagnosis participants experienced mania as a normal part of life; experiencing fluctuating moods was an integral part of their life. However, as the mania went untreated, it escalated, becoming “stronger” and the consequences became harder to deal with.

“ Now dangerous but before.. wonderful, exhilaration. You had all the strength in the world and you could do anything, you did anything with no fear.” (*Participant 4, lines 6-7*). This was a consistent theme.

Bringing in significant others’ awareness when own awareness is missing

“then my son said to me, Mum, you need to go and see a doctor” (*Participant 6, lines 453-454*).

A common theme in participants’ experiences was that awareness fluctuated so that participants were not always aware that they were going into a manic episode. Close relationships with family and friends not only provided support and companionship but helped increase awareness. In fact participants stated that they did not always recognise the ascent into mania, consequently family and friends were pivotal in detecting early warning signs. For example;

“ It’s people who you trust really, sort of you latch on during and after mania, ehm, they can throw light again. If somebody at some point actually told me that I am poorly, because once I am poorly, I don’t know that I am poorly, I think I am enlightened, some kind of mental chandelier. (*Participant 3, lines 387-392*).

Need for increasing awareness

One of the major difficulties in accepting mania as part of an illness was the general lack of education and recognition or awareness. This unawareness was shared by the participants, close others and employees in the health system. This could in part explain that all participants reported having been diagnosed several years after their first manic episode and of being engaged in services.

“It’s just a shame that it took so long to be diagnosed. If when I went to hospital when I was seventeen and was diagnosed and was given those tablets, like two years later, I could have then had mania for two years” (*Participant 7, lines 581-584*).

Once acknowledged, participants began to seek information as exemplified by

“As I said to you, when I was diagnosed, it took me eighteen months. I did a bit of research myself, ehm listening and learning about myself. And it’s like self psychology in a way. It is like psychology awareness and learning”. (*Participant 6, lines 318-322*).

Recovery

The last superordinate theme which emerged within the data was that of recovery. Compassion, acceptance and growth and wisdom clustered around this theme.

Compassion & Acceptance

Being compassionate about oneself was a positive step towards maintaining wellness.

Evaluating one’s life in relation to the illness was part of this process.

Accepting one’s limitations was another aspect mentioned by participants;

“I had this need where I really needed to succeed and it is only sort of in my last years, sort of higher years that I’ve learned that it is okay not to be good. I spent my life living a lie, pretending to be somebody I wasn’t. So I was unhappy. Now I am me!” (*Participant 4, lines 261-263*).

Through personal experience, participants reported learning about themselves and mania. As a result of this, participants made life style changes which promoted and increased stability in their life as well as their sense of agency as exemplified by this participant:

“I think once you had a period of wellness, you know then you start to think ‘This is the life’ and it gives you more of the..kick up the backside to think, ‘Right. This is achievable you don’t have to be like that or you don’t have to worry like that’. Always, it is still going to be a worry but you put yourself out of that daze. You want to be okay”. (*Participant 7, lines 569-574*).

Growth and Wisdom

Participants described that after having experienced mania as an illness, they were more appreciative of mental health problems. Consequently, they felt more in touch with themselves and others who were experiencing and coping with mental health difficulties.

“You do become more sensitive to people, like someone institutionalised and you just become attuned to that to other people”. (*Participant 6, lines 600-601*).

Participants described becoming more appreciative of their lived experience as well as helped them develop a more positive outlook on life

“So it’s like ehm.. Now I don’t say I am this or that. It’s no big deal because I know that today or tomorrow or whatever, it’s gonna be better. And I feel so, like I am really growing into myself now. It’s time to get on now, it’s better and better. Nothing, nothing is ever as bad as you can see.” (*Participant 6, lines 369-372*).

Discussion

The present study aimed to explore the phenomenology of different types of mania in bipolar disorder through eliciting the participants’ own account of manic experiences. A total of five superordinate themes emerged from this study, providing a wider perspective on the nature of mania and indeed reflecting on the broader experience of living with bipolar disorder. Although participants talked about different subtypes of mania, the experience was that these were not distinct from each other, highlighting a broader experience of mania and indicating its mutable and unpredictable nature.

Relating themes to existing literature

A number of factor analytic studies have tried to formally capture factors making up mania. For example, Cassidy, Forest, Murry and Carroll (1998) found five independent factors, namely,

dysphoria, psychosis, hedonia, irritability and aggression. Two other studies such as Gonzalez-Pinto, Ballasteros, Aldama, Perez de Heredia, Guiterrez, & Gonzalez-Pinto (2003) and Rossi, Daleluzzo, Arduini, Di Domenico, Pollice and Petruzzi (2001) replicated these findings, whereas Dilsaver, Chen, Shoaib and Swann (1991) showed evidence for distinct depressed, dysphoric and euphoric presentations. Although these factors were described as having been experienced by participants in this study, it was reported that these were not experienced as independent or distinct from each other (as implied by the above studies) rather they could be experienced simultaneously at any one time. Therefore, participants' experiences of mania were unlike the proposed structure of clearly defined and distinct mania episodes, as proposed by Pedley & Mansell (2008). This broad aspect of mania seemed to make participants experience life as chaotic and unstable.

According to the findings by Lim, Nathan, O'Brien-Malone and Williams (2004), mania symptoms and episodes create major upheavals and cause chaos in those who experience them. According to the participants in this study, chaos seemed caused by the ever-changing nature of mania, as differences in mania were experienced: mania could be experienced as "high" characterised with feelings of elation and grandeur and depressive with the main feature being a depressive mood. Another type of manic experience was characterised by irritability and anger. In some cases psychosis was also experienced. Whilst participants were able to experience differences in mania, these were not experienced as distinct or unrelated to each other which highlighted further the fluidity of mania within the same experience.

In the present study, participants reported that the interchangeable and unpredictable aspect of mania also caused feelings of anxiety similar to the experiences reported by the participants in the Lim et al(2004) study. Anxiety as a component of mania was also reported in the factor analytic study of Swann, Janicak, Calabrese, Bowden, Dilsaver, Morris, Petty and Davis (2001) and more recently in a study by Thompson, Gonzalez, Singh, Schoolfield, Katz and Bowden

(2010). In both studies, anxiety loaded with depression and irritability suggesting that anxiety is only present with these factors of mania. However, in the present study, participants reported that anxiety is always present in mania. In this respect, Thompson et al (2010) write that anxiety is a common occurrence in BD but has not been identified in prior factor analytic studies, in part due to the limited coverage of the variable in the scales used. In the present study however, anxiety is reported to be intrinsically linked with mania.

Fleeting and changing thought processes was a key theme raised by participants in the current study. Pallanti, Quercioli, Pazzagli, Rossi, Dell' Osso, Pini and Cassano (1999) state that compromised thinking in mania is due to a cognitive deficit. Deficit features as a component of mania were also reported in the factor analysis conducted by Aksiskal et al (2003). Related to this, participants talked about unwise decisions or actions taken (during manic episodes) which added shame, guilt, embarrassment and further distress to their recovery. Indeed, there appeared to be a constant struggle for stability and normality in their lives, perhaps in the face of impairments of problem solving and decision making.

Participants reported that psychomotor activation was another core feature in their experience of mania. Psychomotor activation was also another common factor extracted by the studies cited above. For example, Cassidy et al (1998) and Gonzalez-Pinto et al (2003) refer to it as "psychomotor activation", Dilsaver et al (1999) refer to it as "manic activation", Rossi et al (2001) call it "activation", Swann et al (2001) refer to it as "hyperactivity", Sato et al (2002) as "agitation" and finally Aksiskal et al (2003) refer to it as "disinhibition/instability" and give it a central role in their proposed multidimensional structure of mania. Participants in this study talked about a possible interface between psychomotor activation and exhaustion, so that psychomotor activation caused exhaustion and exhaustion begot more psychomotor activation which contributed further to feelings of uncontrollability. To date, it is apparent that this link has not been explored or formerly described by previous research.

Ambivalence towards the manic experience and medication emerged as a major theme in the participants' lives. Although mildly activated states were described positively and were linked to enjoyment, creativity and productivity, participants feared the escalation of symptoms. This ambivalence resonates with the studies of Lim et al (2004) and Mansell et al (2010) whose participants reported that although they appreciated the stability brought on by the medication, the ambivalence was related to feelings of elation and excitement in mania which were dampened or absent in periods of stability. Moreover, ambivalence towards medication was linked with unpleasant side effects but participants were aware that medication helped them remain well. Reflecting the findings of Lim et al (2004), they perceived that they were unable to manage or control their symptoms except through medication, despite uncertainty with regards to its efficacy. However, over time, participants became more accepting of the need to take medication.

Mood fluctuations had a distinct impact on the participants' identity. In fact, mood state was a central factor in creating contradictory selves since the development of who they were was created within the context of a particular mood state. The participants' mood states also influenced the contents of their self evaluations and vice versa which led to a difficulty in differentiating between self and the manic episode. This finding is similar to Inder, Crowe, Moor, Luty, Carter and Joyce (2008) who found that bipolar disorder creates feelings of confusion, contradiction and self-doubt which leaves people unable to form a continuous sense of self. The interpersonal context or others' reactions also contributed to this confused sense of self, as mania influenced the way they felt they were perceived by close others. There was also an awareness of being seen as an "embarrassment". Participants reported that family and peers could not always understand and managing an episode was hard. This tended to cause a lot of disagreements and discontent. In relation to this, Miklowitz and Johnson (2009) have found that families of adults with BD experience more conflict than families of healthy individuals but this

finding was not specific to the manic experience. Furthermore, Miklowitz (2007) proposed a bidirectional relationship between familial interactions and patients' symptoms thus: As escalating negative interactions lower caregivers' thresholds to react with frustration and hopelessness, caregivers may remember and exaggerate negative experiences from past episodes and based on these, make attributions about controllability and make negative predictions for the future.

Avoiding triggers was described as the main way of avoiding mania, coping and regaining control, although participants could not identify different triggers in accordance with different forms of mania, as initially thought. Eventually, backed up with greater understanding and experience, participants were able to recognise triggers early on, so as to avoid an onset of mania. This finding is similar to that reported by Mansell et al (2010) whose participants reported becoming vigilant of triggers so as to maintain wellness.

Given previous research (Lam and Wong, 1997) indicating that patients with BD are able to recognise prodromal symptoms, it was surprising to find that participants were not always able to recognise early warning signs of mania or were aware of experiencing a manic episode. Moreover, awareness of the impact of mania on self and others was generally impaired during an acute phase. Family and friends were pivotal in recognising the first symptoms or signs, a finding that was also reported in Russell and Browne (2005). Similarly to Johnson, Winett, Meyer, Greenhouse and Miller (1999) good social support was found to be associated with fewer episode recurrences as participants reported that the support provided by family and close friends had been an invaluable influence towards maintaining wellness. In this respect, D'Souza, Piskulic and Sundram (2009) assert that emphasising acceptance of mutual responsibility and giving others permission to intervene in case of a relapse, improved outcomes for people with BD.

Although participants believed that they had come to terms with mania, recovery was perceived as tenuous. Post episode, participants reported having had to go through a number of processes such as deeply reflecting about their situation and possibilities towards improvement, dealing with shame and guilt, helpful self talk (even during episodes) and pacing and managing their lifestyle, before a sense of stability could be reached. Similar processes were reported by participants in Mansell et al (2010) study. Finally, the acceptance of self and mania and the assimilation of information and knowledge gained through personal experience, permitted a degree of wellness to be reached and despite a sense of loss, participants seemed able to foster a sense of hope for the future.

Summary of key findings

Many themes in the current study resonate with earlier research. For example, ambivalence towards mania and medication, the detection of triggers, lifestyle factors and changes, conflicting beliefs about the self and the difficulty in maintaining a stable identity and recovery. However, this research is the first to investigate differences experienced in manic episodes and although different manic episodes were reported, these were not experienced as independent from each other, highlighting the complex and mutable nature of mania. The interplay between psychomotor activation and exhaustion was also a key finding. Another novel finding was that while participants were asked to talk specifically about mania during the interviews, they talked about BD and mania interchangeably, perhaps highlighting that mania was not experienced simply as a phase in BD but rather it was understood as a focal or rather an all- encompassing experience of BD. Surprisingly, this research also highlighted that prodromes were not always identified by participants. Linked to this, although the benefits of a good social network in BD has long been established, the current study served to further highlight the active role of family and close others in preventing the ascent into mania and in maintaining wellness.

Clinical Implications

Many studies have examined factors influencing or associated with the outcome of bipolar disorder. However, little is known about patients' subjective experiences of mania and issues that are significant to them. Although a manual based intervention already exists for bipolar disorder, the present research highlights that due to the ever changing nature of mania, patients have to be helped to move on according to their personal views, values and goals as these may change over time in keeping with the kind of mania episodes experienced. This suggests that individualised formulations and treatment plans should always be considered by clinicians working with people with BD.

Therapeutically, at the point of initiating an intervention, the relative stability of the patient has to be ascertained through continual assessment even during the same phase, as patients' views and expressions may be erroneously influenced by the ever changing mood states. There is also a need to continually intervene at a level that is beyond clinical management. During periods of relative wellness, patients could be taught on coping strategies, augmenting personal resources and resiliency, dealing with shame and guilt, helpful self talk (even during an active episode), pacing and managing lifestyle to ensure that a relative stability is reached.

Family members, caregivers or close trusted friends play a very important role in detecting subtle mood changes/ fluctuations. Psychoeducation should be offered to family and peers because if properly prepared and informed, it help the patient therapeutically. In this case, sharing responsibility for future relapse management could be a key approach in maintaining wellness. Family therapy has been used to some extent but further work is needed to verify its effectiveness (Justo, Soares and Calil, 2009).

Methodological Limitations

The sample used within the study lacked homogeneity as it included participants who have not experienced any relapses for some time, (ten and five years respectively) and other participants who experienced mania relatively recently but were out of episode. Participants were asked to retrospectively think about their manic episodes; some memories may have become distorted or faded with time, hence rendering them less accurate. Nonetheless, since IPA is concerned with making meaning, problems created by memory retrieval may be offset by this consideration.

IPA also acknowledges that the perspectives of researchers will influence the interpretation of data and play an important role in the construction of meaning, (Smith 1996). Inevitably, the author's own knowledge and experience of BD informed the type of questions asked and the interpretation of data. However, the author tried to keep close to the participants' "insider knowledge" so as to be able to recognise issues that were important to them. This is most notable by the fact that the themes that emerged were relatively unconnected to the questions asked and brought a change of emphasis, which ultimately reflected more accurately the experience of mania.

Conclusion & future research directions

The symptoms of mania are clearly diverse and vary from individual to individual at different times. Existing models may not be flexible enough to be applied to diverse experiences of mania (Pedley et al, 2008). Indeed, categorising or subtyping mania may not even capture the complexity of the phenomenon, rather it may even limit our full understanding of the way this complex problem affects people. Future research should try and integrate a range of real world assessments such as interviews, self report measures and observations so as to develop a "real world" understanding of how mania develops and is experienced by people with bipolar disorder.

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Appendices

Appendix A

Search Terms

Preliminary Search Terms

(“affective disorders” OR “mood disorder” OR “bipolar disorder” OR
“bipolar psychosis” OR “manic disorder” OR “mania” OR “manic psychosis”
OR “manic depression” OR “affective symptoms” OR “bipolar depression”)

AND

(“ family therapy” OR “family intervention” OR “family treatment”
OR “family process therapy” OR “family management” OR “psychoanalytical
family therapy” OR “psychodynamic family therapy” OR
“supportive family therapy” OR “cognitive behavioural family therapy”
OR “systemic family therapy” OR “interpersonal family therapy” OR “couples therapy” OR
“marital therapy”).

Final Search Terms

(“bipolar disorder*” OR “affective disorders” OR “mood disorder” OR “bipolar disorder”)

AND

(“family therapy” OR “famil* w3 therap*” OR “family intervention” OR “family
treatment”).

Appendix B-
Key Journals Searched by Hand

Bipolar Disorders

Family Process

Journal of Affective Disorders

Journal of Family Psychology

Psychiatry Research

Appendix C

Table 3 Studies excluded because they are a continuation project of other major reported studies

Study ID	Reports on Study /Intervention	Reported Findings
Thase 2007	STEP-BD Program	Highlights the challenges of treating bipolar depression. It illustrates the value of adjunctive therapy to psychopharmacology and discusses future directions in the field.
Reinares 2006	Barcelona Bipolar Disorders Program	Caregivers showed subjective burden when caring for patients with bipolar disorder. Highest level of distress was dependant on patients' behaviours. Poor social and occupational functioning and medication responsibility featured as burdensome aspects as well.
Reinares 2009	Post- Hoc Analysis of the Barcelona Bipolar Disorders Program	The study highlighted that psychological interventions have to be introduced early in the treatment and course of the illness.

Table 4 Studies which used a family intervention but the outcomes assessed did not directly relate to bipolar disorder

Study ID	Sample	Type of Family Intervention	Focus of Study and Reported Findings
Wesley Burgess 2001	Adult with bipolar disorder Case study illustration, 25 year old male. (N=1).	A structured intervention aimed at modifying the family systemic process, in the form of addressing communications, reframing problems, shifting family ideas/ dynamics, so as to obtain effective outcomes for the patient, mainly treatment adherence.	Adapting interventions for pharmacotherapy, reinforcing patients' appropriate behaviour, control and mastery. Acceptable solutions were found for the patient and the family. The patient is reported to have sufficiently recovered to allow him to return to his native country.
Weisman 2002	Adults with bipolar disorder (N=26) and their families .The sample was drawn from a larger project (Goldstein, Rea & Miklowitz, 1996).	Each family received 21 sessions of FFT which consisted of three components, psycho-education, communication training and problem solving.	The study assessed therapist competency and adherence to a manual-based approach to family therapy as a predictor of the course of illness for patients with bipolar disorder. There were no significant associations between therapists' competence/ adherence and patient outcomes.
Rosenfarb 2001	Adults with bipolar disorder (N=27) in remission from a manic episode.	Assessment of family verbal interactions done through observation and audio-taped sessions	The study wanted to examine the relations between family verbal interactions and patients symptoms. The patients who showed high levels of odd thinking and grandiosity during family interactions, were found to be more likely to relapse during a 9-month follow-up.
Tompson 2000	Adults in an acute manic episode, (N=26) and followed through after discharge.	Psycho-education family based intervention	The aim of the study was to examine the relationship between measures of the family affective climate and difficulties in implementing a family treatment. Only the relatives' critical behaviour (pre-treatment) towards the patient predicted treatment difficulty.
Anderson 1986	Adults in active phase of affective disorders, (N=40) depression 57%, 22% depressed	Two treatment multi family groups: A one-off 4-hour process-oriented session to increase	The primary aim of this study was to test whether the two interventions had a differential impact on

	with psychotic features, 10% bipolar disorder and 15% had other related diagnosis.	support, facilitate sharing experiences, decrease feelings of isolation and stigmatisation, or a psycho-educational, didactic treatment group.	illness- related variables as measured by: The Family Coping and Attitude Scale, The Family Attitude Questionnaire, Dyadic Adjustment Scale. Results indicated that there was no difference between the two groups.
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Appendix D

Information Sheet

Participant Information Sheet

Part 1. General Information about this study

Purpose of the study

The research conducted on bipolar disorder is profuse. This piece of research wants to investigate how people with bipolar disorder experience the illness, more specifically the different types of mania experiences, which tend to run on a spectrum from mild to severe. As you may well know, bipolar disorder causes unusual shifts in a person's mood, energy and ability to function. These mood swings cause severe changes in energy and behaviour. This is a lifetime illness and a treatment strategy that combines medication and psychological therapies is optimal for managing the disorder. Psychological interventions have been shown to lead to increased mood stability, fewer hospitalisations and an overall improved functioning but not all people with bipolar disorder respond to them.

A better understanding of the different types of mania seems to hold the key towards improving people's lives. A newer understanding perhaps will eventually lead to developing new ways of working with people with the disorder. This research is intended to open a window of opportunity to explore the nature of different mania experiences as it seeks people's real lived experience. Potentially, this research could open a niche in this direction, as it could provide new information as to how people are affected differently by the different types throughout their lives. Understanding characteristic features or factors and triggers of the different types of mania could allow for better psychological therapies to be developed that take into account the different profiles presented by the different mania phases.

Why have you been invited?

You have been identified as being potentially a suitable candidate for this study. This study is intended to shed light on how mania experiences may differ from each other and how these have affected you, your family and friends and how it may have impacted on other aspects in your life, such as pursuing different life goals, your sense of self-esteem, stress, coping strategies and how you may sought help. This is why your individual lived experience could be invaluable in shedding more light into this phenomenon of mania.

Do you have to take part?

This is entirely up to you and please do not feel obliged that you have to take part. I will be happy to go through this information sheet together with you. If you decide to take part you will be asked to formally confirm this, by signing a consent form, to show

that you have agreed to take part. You are free to withdraw at any time and no reasons will be sought for this.

What will happen if I take part?

If you agree to take part, you are kindly requested to contact me, the researcher at the Department of Clinical Psychology at the University of Hull so that we can arrange an appointment. You would be kindly asked to come to the University to carry out the interview. On the day of the interview, I will initially ask you to some self-report questionnaires. These questionnaires are to ascertain that you are not currently experiencing extreme mood symptoms. If the questionnaires were to show that you may have some serious symptoms of the illness, you would regrettably be unable to take part in the study. At this point, confidentiality may be breached if I come to the conclusion that you may need further assistance, and for your own safety, I would have to report to my supervisor and your designated CPN for further support.

If you meet all the inclusion criteria of the study, then you will be invited to answer to a number of questions which I will ask you. This interview should take about 50 minutes. Even at this point, you are free to withdraw with no consequences to you and any data collected will not be used in the study. For the purpose of this study, this interview will be tape recorded. The tape from this interview will be then transcribed by me. All tapes will be destroyed at the end of this study.

What are the possible disadvantages and risks of taking part?

As explained above, I will need to ask you to fill out some self-report questionnaires before you take part. There may be a chance that your mood may be low or high. This could impair the quality of your recollections during the interview. This is why you would be unable to take part and I will be available to discuss this further with you. Also, if during the interview, you may show signs of becoming distressed or unwell by the memories invoked, I may have to call my supervisor who is an experienced clinical psychologist in the field of bipolar disorder or other members of staff at the department, who are clinical psychologists for support. As above, your CPN will be duly informed. We do not anticipate that this would happen but if it does, we contact other relevant persons such as your GP in order to safeguard you.

Additionally, if any information divulged gives concern either to your health or the health of others, or information of criminal nature is disclosed, I am obliged to breach confidentiality and discuss this issue with my supervisor in this instance.

What are the possible benefits of taking part?

There is no direct benefit from you participating in this research. The information gathered could help improve our understanding of mania. But it is hoped that you could benefit indirectly, as you may find the experience of a sympathetic researcher with whom you can discuss issues that are important to you, may be a helpful and

cathartic experience. The researcher is aware that sensitive information may be divulged during the interview. **You do not have to talk about anything that could cause you embarrassment or any discomfort.**

Part 2: Additional Information for your perusal

What if there is a problem?

If you have any concerns, please do not hesitate to contact me, Sandra Borg and I will endeavour to help you with your queries. In the instance that you are not satisfied, please contact my supervisor, Professor Dominic Lam at the Department of Clinical Psychology. If after this instance you are still not happy, you can formally complain through the Research and Development Department of Humber Mental Health Teaching NHS Trust.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential and any tapes and transcripts will be anonymised and given a pseudonym. Transcripts will be transcribed personally by me and access to these transcripts will be limited to me and my supervisor. Any information which leaves the experimenting site will be anonymised and your names and addresses will be removed and kept separate. This research is intended for publication but you will not be identified personally in any publication.

What will happen to the results of this study?

I intend to ask a few of the participants to comment on the results of this study. It is important to get some feedback if the interpretations of the results make sense to the participants. I also intend to publish this research in relevant scientific journals which deal with clinical psychology and mental illness. If you are a participant and wish to receive a copy of the manuscript, a copy will be forwarded to you. As a gesture of gratitude for taking time to participate in the study, a summary report of the key findings will be distributed to all participants.

Who is organising this research?

This research is a student project which counts towards the doctoral degree in clinical psychology (Clin.Psy.D). This research is being organised by me, Sandra Borg. The supervisor for this project is Professor Dominic Lam (contact details given below).

Who will review this study?

All research in the NHS is looked at by an independent group of people who form part of the Research Ethics Committee. This is done to safeguard your safety, rights, wellbeing and dignity. This study will be reviewed by the Hull and East Riding Research Ethics Committee.

Contact Details

Sandra Borg (01482) 464101 .M.Borg@2007.hull.ac

Professor Dominic Lam (01482) 464164 .Lam@psy.hull.ac

Research and Development Department of Humber Mental Health Teaching NHS Trust
(01482) 301723.

Consent Form

Title of Project: The Experience of Different Episodes of Mania in Bipolar Disorder

Name of Researcher: Sandra Borg

Name of Supervisor: Professor Dominic Lam

Please initial the following boxes:

1. I confirm that I have read and understand the information sheet dated 05/07/09 (version 1.) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I understand that data collected during the study, may be looked at by the Researcher and the Researcher's Supervisor at The University of Hull, where I am taking part in this research.

☐

4. If needed, I give permission for these individuals to have access to my records.

☐

5. I agree to take part in the above study.

☐

6. I would like to receive a report summarising the results of the study.

☐

7. I would like to receive a copy of the final manuscript.

☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix E

Interview Schedule

A. Is each experience of mania qualitatively different?

1. **Many people state that they are able to distinguish different types of manic episodes. What are your thoughts about this?**

Prompt: Were you able to recognise any differences between each manic episode?

Prompt: How were they different?

Prompt: I am interested to know how you would describe them. What adjective would you use to best describe them?

Prompt: If you were to think back about the last three episodes, what words would best describe the manic episodes you have had?

B. Were preceding factors and triggers different for each type of mania? How did they affect the course of the type of manic episode experienced?

1. Now, I would be interested to know about events surrounding the onset of mania. Does anything come to mind?

Prompt: Can you remember any factors or events that might have preceded the manic episode?

Prompt: What was it like?

Prompt: Can you remember any triggers?

2. **Just earlier on you talked to me about experiencing different types/ or not experiencing different types of manic episodes. Thinking about this, can you tell me how events or factors preceding each episode were different or similar?**

Prompt: In what ways were they different/ similar?

Prompt: Can you tell me a bit more about this, please?

3. **In your experience, how did these affect the course of the manic episode?**

Prompt: What is your understanding?

4. Prompt: Have you ever had the opportunity to think and discuss this, perhaps with family and friends?

Prompt: Is there a link? What is your opinion about this?

C. Can different life events and goals be associated with the different types of mania?

So far, we have spoken about the events and factors surrounding the onset of a manic episode and how these have affected (or not) the course of the type of mania experienced. Now I would be interested to know more about pursuing goals and different life events. Again, I would like you to think about the past three manic episodes.

1. **Could you tell me more about how the manic episodes influenced (or not) certain choices you have made or not made?**

Prompt: Did you pursue any particular goals at the time?

Prompt: Were they in accordance with each type of manic episode experienced?

Prompt: Were they different each time for each manic episode?

Prompt: Can you think of any life events that you pursued as a result of the type of manic episode experienced?

D. With each different type of mania, what kind of coping strategies were employed?

Thank you for the useful information you have given me so far. We are not just finished yet. I would now like to ask you one more question. I have just asked you about life events and pursuing different life goals. If it is fine by you, I would now like to ask you some questions about coping strategies you may have used.

1. **Could you tell me what strategies you find helpful towards you being able to cope with the different manic episodes?**

Prompt: Does each manic episode dictate whether you seek any help (to cope or not)?

Prompt: Do you seek any help from family and friends?

Prompt: Thinking about your last three episodes, what coping strategies have you employed?

Prompt: Were they different for each different type of mania?

Prompt: What did you find most helpful/ least helpful?

Prompt: Did you seek any help from professionals, for example your CPN?

E. Concluding the interview

1. **In relation to what you have been able to tell me today, about your experience of different types of mania, is there anything you would like to add to support the information you have given me?**

Prompt: Is there anything else you would like to tell me?

Prompt: Has anything been missed?

Prompt: Is this what you expected to talk about today?

Prompt: How have you found the interviewing process?

Prompt: Are there any suggestions you would like to make about improving the interviewing process.

Prompt: How can it be facilitated for participants?

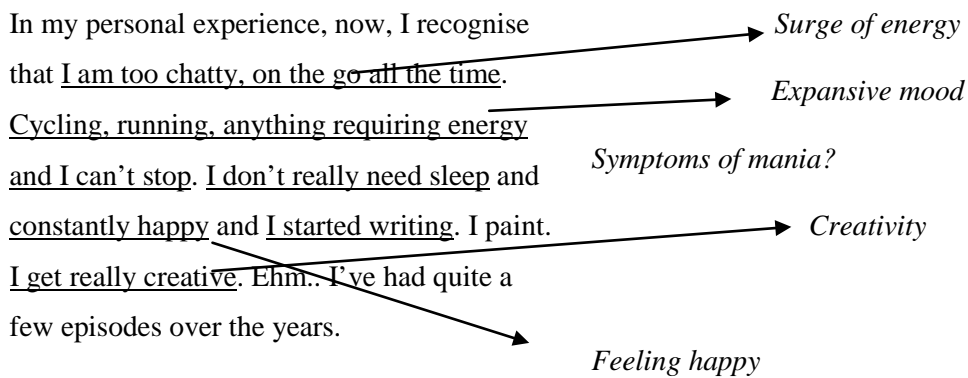
Thank You for your time and contribution.

Appendix F

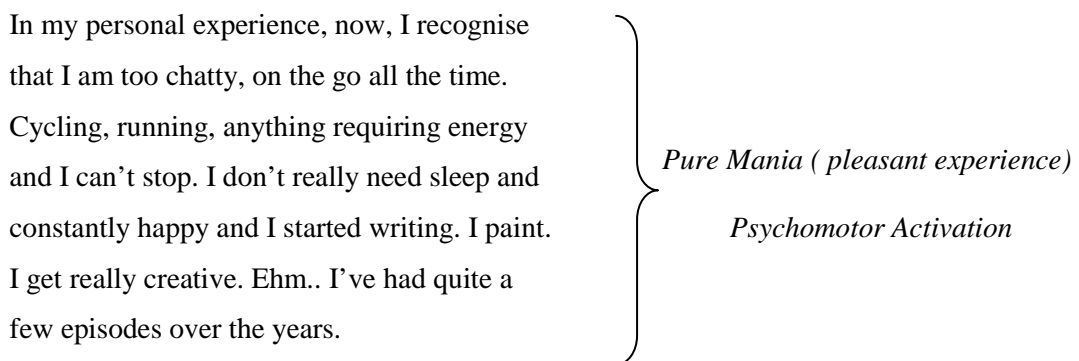
Example of Data Analysis

The process began with making initial notes against the text. This could entail anything from the author's own impressions and feelings to more objective comparisons with other aspects of the text or the relevance of theory and literature (Smith, 2003).

An example is shown below:



At the second stage of analysis, transcripts are re-read and notes are grouped into smaller themes. For example



Appendix G

Reflective Statement

The process of conducting a large scale project often involves a steep learning curve. This has certainly been my experience whilst I was conducting the research documented in this portfolio thesis. However, I have to acknowledge that this was my first experience of conducting a bigger research project, in another language. The purpose of this reflective statement is to reflect on my learning process on conducting research.

It has been a long journey with long winding paths encompassing various turns: naively, I was not expecting this. I was hoping it to be a smoother process, after all I had gone through a thorough preparatory phase after having failed the review of my fourth research proposal. After that initial setback, I ensured that I had a reasonable understanding of the topic which I was going to research: bipolar disorder.

In my opinion, bipolar disorder is one of the most fascinating conditions we encounter in psychiatry and clinical practice. At the same time bipolar disorder is one of the most severe psychiatric disorders, not easily amenable to change not even with the appropriate medication management or optimal clinical conditions.

I remember in those old days at the University of Malta when I was reading for my degree in Italian Language and Literature, I was fascinated by the remarkable creativity of masters of literature, poetry and art of the calibre of Dante, Torquato Tasso and Michelangelo, all of whom were afflicted by affective disorders.

Then, in my clinical practice I came face to face with the harsh reality and desolation faced by patients and their families and my interest in the disorder grew from there. An inevitable outcome of the research process has been that I am now more able to comment knowledgeably on the topic, although I appreciate that there is so much more to learn.

Whilst reading for my research, I was drawn to all sorts of papers published on bipolar disorder and at times, on finding that some papers were more appealing than others, I continued reading,

at times losing track or focus of my research question. Perhaps this is one facet of my character: sometimes I tend to wander off with my thoughts and I like thinking about different possibilities and connections. Although I find this an interesting endeavour, many a time this was not conducive to the research process and luckily my supervisor, with his feet firmly grounded, took the task, to bring me back to reality and focus. Through this process, I have learned that remaining constantly conscious of the foundations for the research project may serve to contain wandering ideas and provide a time-effective tool against which to assess the relevance and application of the information I was reading.

Subtypes of mania are a relatively recent idea in bipolar literature. It stemmed from factor analytic studies, as researchers were discovering similar factors or components which made up mania. The theories around the development of mania abound but no one has as yet specifically conducted research to verify the veracity of the existence of discrete categories of mania.

Occasionally, this has provoked some anxiety as whilst researching the topic for my literature review, mania literature seemed to focus on medication prophylaxis, making me doubt the relevancy of the topic I was researching. On the other hand, I had to learn to contain my anxiety and trust in the experience and expertise of my supervisor who recommended this line of research in bipolar disorder. After trying different combination of terms without success, I finally discarded the idea of conducting my systematic literature review on subtypes of mania. In retrospect, I should have done this earlier on in the process.

The fact that subtypes of mania is an under researched topic reinforced the idea that the mode of research was employed to answer my research question was appropriate as qualitative research usually lends itself better to study under- represented phenomena, in research. Whilst reading about how to conduct qualitative research, I came to the realisation that after all, qualitative and quantitative research methods are complimentary to each other and both orientations require rigour in different ways.

One area in which I experienced a particular setback was in the process of participant recruitment for the empirical study. I have come to realise that I was somewhat naive when

planning the recruitment process. I had hypothesised that recruitment would be a straightforward process and participants would be “flooding in”. After all, I only needed eight participants! How wrong I was! I underestimated both the time that recruitment would take (I interviewed my last participant on the 10th of June) and the extent to which staff in the local CMHT’s would be able to contribute to recruitment. In the end I recruited enough participants, albeit later than anticipated. I should have allocated more time to the recruitment process.

The best part in the process of conducting research for the empirical paper, was meeting with participants and listening to their stories, their lived experience of mania. I remember the first flickers of excitement, as one after the other confirmed the existence of different types of mania. Finally, I had a tangible proof that this research was well worth the effort. I feel enriched and at the same time humbled by their experiences and I am grateful to them for letting me have a glance into their lives, albeit through a glass, darkly, as perhaps, only those who come face to face with mania can truly understand it’s complexities.

I was looking forward to use IPA as a method of analysis as in the past I have had the experience of using quantitative methods but I was never exposed to qualitative modes of researching. This represented my first “hands-on” experience of conducting qualitative research. It was not easy, in fact it was harder than I had anticipated. Moreover, to counteract for my anxiety, I spent hours reading chapters from different authors detailing how to do it, making sure that I understood the approach, rather than starting to analyse data. I have to admit that this procrastination on my part, did not pay dividends. It took me a while to actually immerse myself in the data and “just do it”. I have learned that through doing comes a better understanding of conducting a qualitative analysis.

“Stop, rewind, restart” are the three words that would illustrate the iterative process I have gone through, whilst conducting the IPA. Qualitative research entails a personal responsibility to represent at best, the experience of participants. Rigour is called for and I felt under pressure to describe as best as I could, the participants’ experience. I found myself reflecting on my approach to data analysis. I was constantly aware that the process required a search for meaning

via reflective interpretation, rather than emphasising frequency of ideas and this has been a long, taxing and time consuming process. The desire to make the participants' voices heard and my enthusiasm for the topic have given me the impetus to carry on when disheartened.

Qualitative research requires reflexivity on the part of the researcher. As a novice researcher, I found myself constantly reflecting on the reasons of my undertaking this project, the nature of my involvement in the research process and the way this could have shaped its outcomes. I was aware of my pre-set assumptions, my understandings and meanings I had formed of bipolar disorder and mania along the way. I found myself stepping back and putting them aside, as I tried to listen to the participants' voices and their interpretation of their lived experience of mania. But this was only one stage of the process. At the next stage of the process, as meanings emerged and evolved from the texts, I found myself revisiting the raw data, that is, the interviews and cross- referencing them with the emerging themes, so as to make sure that my evolving understanding matched with the texts. I continued with this "back and forth" process, until I was satisfied that, my understanding was a close and faithful approximation to the participants' experience.

Despite working hard at this project I have learnt about my weakness in terms of time management. The two articles represent two different streams of research and I underestimated the stages involved in completing both.

I believe that the empirical paper provides a valuable insight into the experience of people experiencing the fluctuating and unpredictable moods of mania or rather the different subtypes of mania. I decided to write this article for *Bipolar Disorders Journal*. It is a peer- reviewed international journal which aims to disseminate information of bipolar disorder through the dissemination of research.

The systematic review paper was written for *Family Processes*. This is an international multidisciplinary journal. The journal is a major resource for mental health and social service professionals who are looking for research and clinical ideas about family, systems theory and

practice. A multi- disciplinary journal seemed an appropriate choice since in practice, family therapy is practised by a wide range of professionals other than psychologists.

Appendix H

Systematic Literature Review

Word Count: 7465 (excluding abstract, tables, figure, references & appendices)

Maximum: 7500

Empirical Paper

Word Count: 7450 (excluding abstract, tables, references & appendices)

Maximum: 7500

Appendix I

Family Process

Instructions for Authors

Tips in Spanish and Mandarin for Writing for *Family Process* follow the instructions in English below.

***Family Process* Electronic Editorial Office** To submit or review a paper, go to <http://mc.manuscriptcentral.com:80/fp>

The **NIH Public Access Policy** is also listed below.

Submission of Manuscripts

All submissions are electronic. Authors should submit manuscripts to the Family Process submissions website (<http://mc.manuscriptcentral.com/fp>). By accessing this website you will be guided stepwise through the creation and uploading of files. For assistance, contact Scholar One technical support at 888-503-1050 or via email at mcsupport@thomson.com.

Electronic manuscripts must be double spaced in 12 point font throughout, including the abstract and references with page numbering consecutively with the title page as page one, abstract, text, references, and visuals. The submission form requires the name, mailing address, email address, telephone number, and FAX number of all authors including the corresponding author.

All correspondence, including Editor's decision and request for revisions, will be by email. Manuscripts must be in English and submitted exclusively to *Family Process*. If accepted, papers become copyright of the Family Process Institute. Authors must give signed consent for publication by submitting a Copyright Assignment Form, but permission to use material elsewhere (e.g., in review articles) will normally be granted on request.

General Requirements:

In a cover letter, please include the word count of the article, and the address, phone number, and if possible, fax and e-mail address of the principle author. Authors will be advised of the decision about their manuscripts as rapidly as possible. Manuscripts are received with the understanding that they are not being submitted simultaneously to another publication.

Authors are requested to prepare their articles in conformity to the *Publication Manual of the American Psychological Association* (refer to previous issues for reference). Papers should be written clearly and concisely, using gender-neutral language and jargon-free prose. Brevity is also desirable. Manuscripts should not exceed 6,000 words (including tables and references). All case reports should protect patient confidentiality.

Authors:

Because *Family Process* uses a blind review system. The authors' names should not be included on manuscript pages. Identifying information for each author, including professional degree/title, and name and location of the principal institutional affiliation, along with the complete mailing address of the principal author, should be included in the online submission. Upon acceptance, the principal author will receive a copyright transfer form and an off-print order form. These must be returned immediately upon receipt. In addition to the principal

author's address, also include the address for all other authors to receive complimentary copies of the issue.

Acknowledgements:

Any listing of grant support or special appreciation that the authors wish to include should be included on the cover page. If the article is accepted for publication, this information will appear in another footnote on page 1.

Opening Summary:

For full-length articles, the author should include an abstract of approximately 200-250 words. Research articles should use the standard categories of introduction, methods, results and discussion. In articles describing theory, training or clinical interventions, the abstract should make it possible for the reader to have a brief overview of all relevant aspects of the work, including the intent, scope, general procedures, and principal conclusions. For brief reports, these summaries should be similar in content, but limited to 100 words.

References:

An important responsibility of the author is the preparation of a correct reference list, double spaced and located at the end of the article. References should be checked against original sources.

References in Text:

First citation may include up to 4 names (NB: et al. = "and others"); more than 4, cite first 3, et al., date. Subsequent citations: include dual authors; more than 2, cite first surname et al., date. Serial listings: alphabetize by surname of first author.

Reference List: Alphabetize by surname; list all authors; spell out journal names: abbreviations for journals and shortcuts (ibid., op. Cit.) are not acceptable. (See following examples.)

Articles: Ackerman, N.W.(1971). The growing edge of family therapy. *Family Process* 10:143-156.//Smith, N., Smith, A., & Jones, P. (1968)....

Chapters: Goldstein, M.J., & Strachan, A.M. (1987). The family and schizophrenia (pp. 481-509). In T. Jacob (ed.), *Family interaction and psychopathology: Theories, methods, and findings*. New York: Plenum Press.

Edited Books: Wynne, L.C., McDaniel, S.H., & Weber, T.T. (eds.). (1986). *Systems consultation: A new perspective for family therapy*. New York: Guilford Press.

Quotations: Page number(s) must be provided.

Footnotes: A superior number at the appropriate place in the text should indicate the appearance of a footnote. The numbered list of footnotes, typed double space, should be located after the reference listing.

Headings: The journal uses a bi-column format; headings must be short. Within the text, three levels of headings are used: major heads are centered, boldface capitals, thus:

METHOD

Major subheads are flushed left, boldface, with initial capitals, thus:

Family Constellation

Minor subheads are flushed left, italicized, with initial capitals, thus:

Case Example

Tables: Use a separate sheet of paper for each table.

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